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Caring Enough to Cure

Diagnosing the
Disease-Poverty Syndrome

Council for Primary Health Care
Manila, Philippines

CPHE

Caring Enough to Cure

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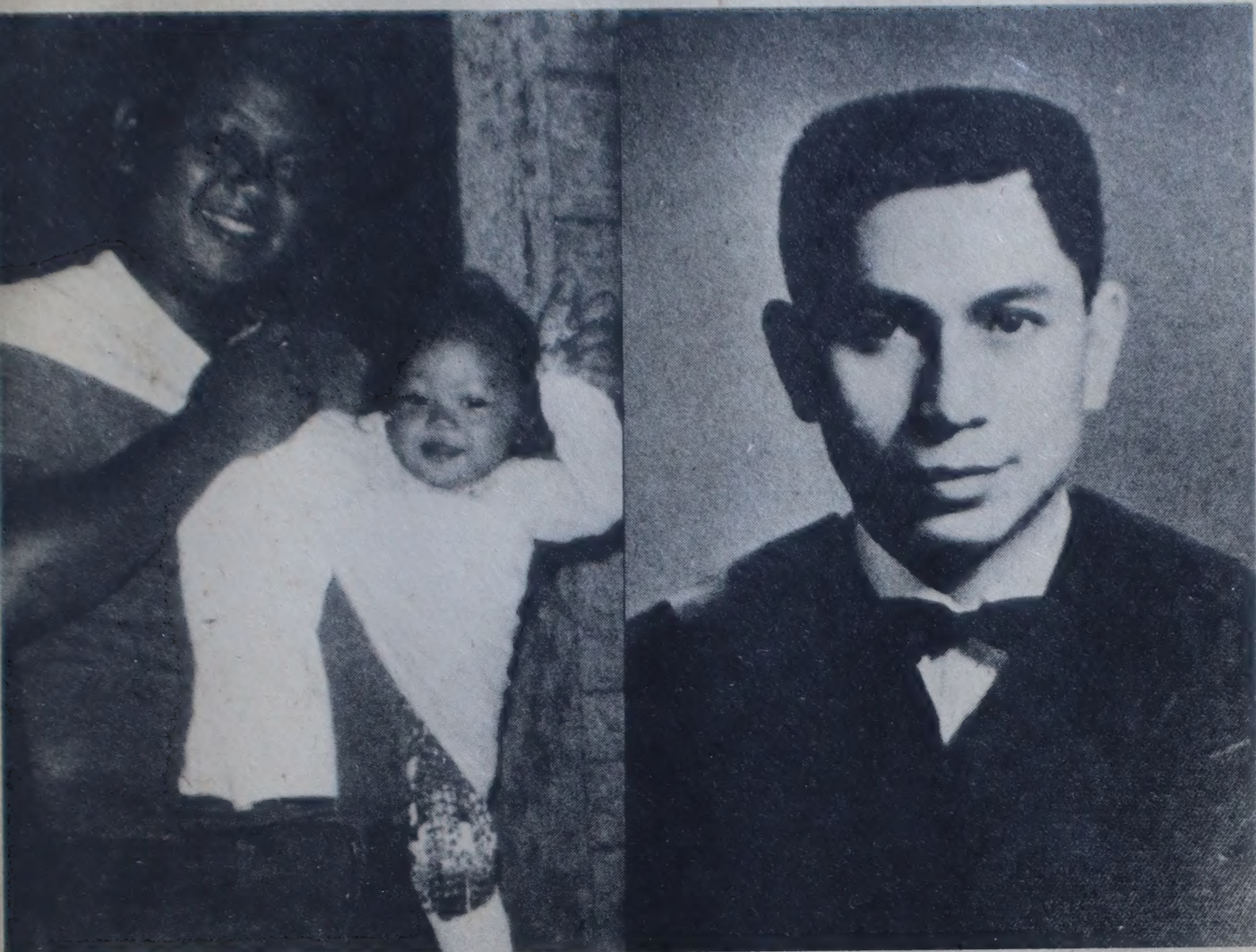
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To Bobby and Johnny, doctors of the people

Dr. Remberto de la Paz died on April 23, 1982 from multiple gunshot wounds at his clinic in Catbalogan, Samar. He was 29 years old.

Dr. Juan Escandor died on March 31, 1983 from multiple gunshot wounds somewhere along Bohol Avenue, Quezon City.

Message from a Mother

May 16, 1986

It has been so often said that a nation's wealth is reflected in the state of health of that nation's children. In our country, however, when we take a look at the present health situation, we do not get a true gauge of the wealth of our nation. Most diseases that have been eradicated in developed countries still rate as our commonest killer diseases: tuberculosis, pneumonia, gastro-intestinal diseases, and parasitism, to name but a few. On the other hand, there are the much-touted "luxury" centers for heart, lung and kidney and there are programs and programs and more programs on paper for the improvement of the health care delivery system. Yet we have remained mired down in the morass of general ill health. Why? What is wrong?

A prolonged and in-depth study of our health situation is hardly necessary. The need is for a re-awakening of moral values, for the re-defining of meaningful terms, for the cleansing and uplifting of social sense and, therefore, health consciousness.

In the recent dark and vile past, our youth had no models to serve as guideposts for their total personality growth, no directions and goals towards self-fulfillment. They grew into young adults exposed to the world where material wealth was the end all and the be all of existence; where licentious freedoms were cultivated and encouraged, even glorified. Whither, therefore, "the hope of our Fatherland?"

And for our health workers, the now and the yet to be, what lies ahead? In the exhilaration of the events of February 1986 and the democratic freedoms we now seem to enjoy, let us renew the vows and oaths we took to dedicate and commit ourselves to the service of our people.

Service in the truest sense of the word as was envisioned by both Johnny Escandor and Bobby de la Paz is what we mean. They had dreams of improving the health condition of our people. They brought no new-fangled technologies to the barrios. They had only their book-learning and the willingness to teach and learn from the people. They were armed with honesty, sincerity, compassion, dedication and commitment. They also thought they could count on the protection of their Hippocratic Oath and on the Universal Declaration of Human Rights when they dared to accept the challenge of their calling; when they dared to make their dreams come true.

That they paid the ultimate sacrifice together with countless others in their quest for a just society is the greatest tragedy of our own Dark Ages. But, they showed the way. A better life and improved health can be had by all. Let us show the world that like the proverbial phoenix, we can rise from the ashes of our past to build our country in an atmosphere of peace, freedom, justice and democracy where life for the toiling masses can be free from want and disease, able to secure for themselves economic stability so necessary for the maintenance of peace and order and the imperative goals that will allow true national sovereignty to become a reality.

Lydia R de la Paz

Introduction

This book was overtaken by a "revolution." It was in the process of being edited when the snap election called by then President Marcos for February 7 triggered a chain-reaction of largely unexpected events that ultimately drove the Philippine strongman into exile.

Written during the final year of the two-decade long Marcos era, the book's trenchant criticism of the country's health system may now seem out of place with the far more hopeful tenor of the times under the government of President Corazon Aquino. Still, it remains relevant because — to paraphrase a French saying — while so much has changed, so much remains the same.

President Aquino rose to power on the crest of a remarkably peaceful popular uprising cum military revolt. But the political upheaval has yet to be followed by a social revolution that would dismantle longstanding structures of gross inequality and injustice that pre-dated Marcos's authoritarian rule.

The country's health care system reflects such deeply-entrenched inequalities. And efforts to overhaul the system — to make it more responsive to the needs of the people — will require commitment and perseverance as dogged as that which animated the "people power" militants.

This book aims to help that process of change along by focusing on the key problems within the health sector and presenting a broad agenda for fundamental change. It was written mainly for the layman. But doctors, nurses and other health professionals may profit from it more in so far as it gives them a chance to critically reflect on their work.

This book is largely about the social and political dimensions of the health crisis. And there are reasons for that. Though this crisis involves a welter of different factors (technological, financial, cultural, etc.), the key factors are political and social.

Medical science has already developed the means to save countless lives and to enrich the lives of many more. But these means are not available to most Filipinos. Or more precisely,

social and political structures deny them such access and thus condemns them to what are really needless misery and tragedy.

This emphasis on the social dimension of the crisis runs through the five chapters of the book. Chapter I, written by journalist Divina Paredes, provides a framework for looking at the country's health situation. It details rather painful proof that children of the poor are bearing the brunt of the health crisis. Ms. Paredes also shows that — after the decades of all sorts of health campaigns — the people are still plagued by virtually the same cast of killer diseases. If anything, this indicates that the same underlying problems that give rise to such a situation remain unsolved.

Michael Tan, in Chapter II, plunges into the nitty gritty of the health care delivery system — from the monumental “centers” to the humble rural health clinics. He paints a picture of a system under growing strain from both within and without. The economic crisis has clearly taken its toll, starving government hospitals for example of badly needed resources and depriving people of incomes to pay for medical care.

But the external shock only serves to highlight the system's internal flaws; its structural bias against the rural and urban poor, its misdirected priorities that resulted in the construction of expensive “centers” while basic health care centers go unfunded and its preoccupation with more costly curative rather than preventive measures.

In Chapter III, Dr. Esperanza Cabral shows how the country tried to produce more doctors and other health professionals to serve the people's needs — and ended up with less. Rising costs of medical education have become a remorseless mechanism for weeding out all but the most financially fortunate students. And even as the price tag of a medical degree rises, the quality of education declines. Those who do pass and win their licenses are ironically hard-put finding the institutions within which to practice their professions.

Professor Minda Luz M. Quesada calls attention to the deplorable lack of quality in the work-life of nurses and other health workers in Chapter IV. Overworked and underpaid, health workers must contend too with the lack of job security and intimidating obstacles to the exercise of their rights to self-organization.

Journalist Gemma Nemenzo-Almendral examines the drug industry in Chapter V. The question that is raised by this chapter is rather knotty: Is profit-making by private (mostly

foreign companies) compatible with the health interests of the Filipino people? The answer, it appears is: to some, yes; but to most, so sorry.

It may be unfair to make too much out of the fact that pharmaceutical firms — particularly the multinational subsidiaries — are among the most consistently profitable in the country. Efficiency, after all, has its rewards. But it is another matter when — as Ms. Almendral describes in her chapter — the drug industry employs its considerable clout to torpedo attempts to put up a program emphasizing the production and importation of low-cost essential drugs.

The last chapter deals with the most vexing question: So? What now? What can be done to overhaul the system? There are unfortunately no simple answers, no short-cut solutions. The chapter does however propose certain directions and identifies some key issues that have to be tackled.

The basic thesis is that health care is too important to be left to a hodge-podge set-up wherein it is hoped that private interest will take care of the public welfare. Bold initiatives to bring health care where it counts — to people at the grassroots will require more funds, more defined priorities and greater social commitment than both the government and the private sector have demonstrated so far.

It will also require more ingenuity and more guts — to deal for example with some foreign companies who have tended to thumb down socially necessary measures that disturb their profit-making.

The book ends with an Appendix which collates basic information on the country's health situation and the health care system. This section is introduced by a brief discussion of how to make heads and tails out of the often confusing data churned out by the government in the past. The situation may improve now that the new government has committed itself to releasing accurate facts and figures.

That is important because little headway can be made unless the myths that shroud health cares is put aside. Hopefully, this book will help do just that.



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The Country's Health Profile

The Statistics of Continuing Misery

by Divina Paredes

Maribel, a one-and-a-half year old girl, died from bronchopneumonia, a complication resulting from severe malnutrition. She lived in a slum community just at the back of a plush village in Makati, the country's financial center. Doctors and volunteers of a foundation helping Maribel's community said at least six children in the neighborhood suffer from "terminal stage" malnutrition. Scores of other children suffer from first and second degree malnutrition. Most of them also harbor parasitic worms.

Poverty and disease are close relatives, goes one Chinese saying. As the Philippine economy sinks deeper into crisis, the consequences of that tragic kinship are becoming increasingly stark.

Government data on the country's health situation though seem to paint a different picture. Official figures show several key health indicators have improved in recent years. These include trends regarding child and maternal health — widely considered as a particularly sensitive indicator of the general health situation — and morbidity and mortality patterns.

A closer look at these data leads to another conclusion.

Are Children Getting Healthier?

According to data of the Ministry of Health, the answer is "Yes." A case in point is the Infant Mortality Rate, or the IMR, which counts the number of infants who die before reaching the age of one year per 1,000 live births in a given year.

The IMR has been steadily decreasing for the past 20 years, says the MOH. Starting from 81.5 in 1965, the rate slipped to 78.3 in 1970. Five



years later, the IMR slid further to 75, then 63.2 in 1980 and finally 58 in 1984.¹ (In percentage terms, an IMR of 58, for example, means that 5.8% of children born in a given year die before they reach the age of one.)

These figures have however been questioned. Independent studies by demographers and pediatricians² suggest that the official IMR understates infant deaths and that the real rate is closer to 80.

Also, the national average figures obscure the wide variations in the IMR between regions. This hides how severely certain population groups, particularly in the rural areas, suffer from high death rates among infants. In 1980, for example, Mindanao's IMR was somewhere between 95.9 to 112.8.³ In urban poor communities in Metro Manila, the rate was reported to be as high as 130. Meaning 13 out of a hundred children never reach the age of one.⁴

Prospects for the future are hardly encouraging. In surveying the social consequences of the country's current economic crisis, a group of professors of the University of the Philippines' School of Economics warned that "a worsening of infant mortality is distinctly possible".⁵

In any case, even if one accepts the official IMR, the death count of infants still adds up to a staggering 100,000 yearly. The casualty tally in this silent massacre is much greater than those of such spectacular disasters as typhoons, earthquakes, airplane crashes and the like.

The grim process of attrition continues for those children who survive infancy. Toddler mortality (deaths between the ages of one to four years) is also intolerably high. Infant and toddler mortality rates combined account for nearly 40% of *all* deaths yearly.⁶

The real tragedy is most of these deaths are preventable. The worst child killers (from birth to age nine) are bronchitis, pertussis (whooping cough), tetanus, measles and diarrhea. *All these diseases are curable. More importantly, they are preventable through immunization, better housing conditions, clean water supplies and adequate nutrition.*

According to the World Health Organization (WHO), 83,000 of the roughly 100,000 annual infant deaths in the Philippines can be avoided through effective immunization programs.⁷

The country's health picture (particularly as it concerns children) comes into sharper focus when the problem of malnutrition is examined.

Are Children Better Fed?

"I had to let them go so they may live," said a father when he left his two youngest children in a government nutrition center for children. The five-year old girl and four-year old boy had match-stick limbs and shrunken buttocks — obvious symptoms of severe malnutrition. Their father, a machine operator earning some ₱200 weekly recalled that the youngest of his eight children often ate sand when he was hungry. He said he had no choice but to let them stay in the government center where they can be better fed. The problem was how to feed them well after that . . .

Being "payat" (thin) is almost a norm among Filipino children. About one of every five children are delivered with "low birth weights." The incidence of this condition, which reduces the newborns' chances for survival, has not gone down from 1978 to 1983, according to WHO report.⁸

The skinny child is such a common sight that, some studies say, many low-income mothers may not recognize under-nutrition in their children simply because all the other children in the community are also under-nourished.

Yet, under-nutrition kills. In all age groups, malnutrition and avitaminoses (diseases caused by vitamin deficiencies) make up the eighth leading cause of death in the country. Among infants, they are the No. 5 killers.⁹

Indirectly, malnutrition accounts for even more deaths in the sense that it makes affected persons more susceptible to all sorts of diseases. Measles, for example, should not be fatal. But in communities teeming with malnourished children, the disease goes on a rampage wiping out scores of lives within a few days.

Several government studies were done in the 1970s to assess the nutritional status of children, who were identified as the age-group facing the highest risk. While the figures vary, these surveys indicate that between 70% to 80% of Filipino preschoolers (below the age of seven) suffer from different degrees of malnutrition. Between 5% to 7% of the surveyed pre-schoolers suffered from third-degree malnutrition, which is the most serious form.¹⁰

Has the picture improved? Government agencies have been reluctant to release complete figures for their nutrition surveys conducted in the 1980s. The Food and Nutrition Research Institute (FNRI) recently released data claiming that 1982 survey showed "only" 17.2% of pre-schoolers suffered from moderate (second-degree) and severe (third-degree) undernutrition, down by almost half the 30% reported in the Institute's 1978 survey.¹¹

However, the Institute's rather sanguine readings of its 1982 survey clashes with other studies of the agriculture ministry and the FNRI itself which show that food consumption for all age-groups has been deteriorating since 1970.¹²

FNRI's own food consumption figure for 1982 cited in the 1984 *NEDA Statistical Yearbook* for example show that protein intake for Filipinos went down by 3.2% between 1978 and 1982 nationwide. The situation was worse in Metro Manila, where a 12% drop was recorded.

This is hardly surprising considering the drop in people's incomes and living standards due to the economic crisis spawned by the country's debt problem. According to data from the National Census and Statistics Office (NCSO), one out of every two Filipino families ate less than the *minimum nutrition levels* as of end-1983. That translates into something like 4.8 million families or roughly 29 million people (assuming an average family size of six).

Moreover, the economic crisis has apparently worsened the maldistribution of income. NCSO data show that the share of the top 20% households (in terms of income) rose from 53.4% in 1983 to about 60% as of the second quarter of 1984 — the biggest jump in seven years.

In contrast, the share of the bottom 20% (or households receiving less than ₱1,000 monthly) dropped from 4.6% in 1983 to 3.4% in 1984.

Even if the 1982 FNRI survey is taken at face value, there is still much to worry about. One of the survey's disturbing findings is that



Vitamin A deficiency can be treated before it leads to blindness.

about one out of four Filipinos are anemic. Again, children are the hardest hit. Infants registered the highest rate of iron deficiency — 51.3%, while the one to six age group posted an anemia prevalence rate of about 32%.

In this regard, specific nutritional deficiencies also should be discussed in terms of their debilitating effects. Iodine deficiency, for example, which is most often manifested as goiter, is endemic in various regions of the country, particularly in mountainous areas where the lack of seafoods denies the population of iodine sources.

More significantly, pregnant women are also susceptible to goiter. About 12% of them suffer from goiter because pregnancy significantly raises the need for iodine. Pregnant women with this condition face greater risks of delivering babies with congenital problems like cretinism, deaf-mutism, dwarfism, mental retardation and neurological incoordination.

Another big problem is Vitamin A deficiency. Unchecked, this nutritional condition leads to xerophthalmia and could eventually result in blindness. The prevalence of Vitamin A deficiency in this country apparently accounts for the fact that the Philippines has the third highest rate of blindness in the world. In absolute terms, some 1.2 million Filipinos suffer from varying degrees of blindness.

In any event, children are bearing the brunt of all these problems. Using weight for-age standards, the FNRI survey shows that almost 70% of pre-schoolers suffer from varying degrees of malnutrition, including mild, moderate and severe forms.

The desperate father's two children cited above fall in the last category. The boy tipped the scales at 7.83 kilograms, while his sister weighed 8.52 kgs. The normal weights for children their ages are 13.18 kgs. and 15 kgs., respectively.

Children with moderate and severe malnutrition will die from malnutrition itself or from diseases aggravated by the lack of adequate food intake. If they survive, these children carry the irreversible effects of nutritional deprivation. Studies show that the most crucial period for a child's mental and physical development takes place before he reaches the age of five. The country therefore faces the *permanent* problem of having a growing portion of its young population handicapped by stunted physical and mental capabilities.

Why Should the Producers of Food and Wealth Go Hungry?

The country's malnutrition problem poses at least two paradoxes. The first is the Filipinos' nutritional status has deteriorated precisely during a time when available food supply has been increasing.

The problem can't therefore be reduced simplistically to backward food production. NEDA's figures suggest that there is enough food per capita. Apparently, the problem is one of equitable distribution. A few have much to eat, perhaps too much (thus, in a sense, suffering from another kind of malnutrition). Meanwhile, most Filipinos are eating less and less, leading to such extreme situations as that which has plagued the troubled island of Negros since 1984.

The tragedy in Negros is of course an extreme case brought about by the collapse of the sugar industry which depressed the island's monocrop economy. An estimated 250,000 workers were displaced, starting a wave of hunger that was, by late 1985, reportedly claiming the lives of about 50 children daily.

The added paradox is that even those "gainfully" employed suffer from malnutrition, a situation that stems from dismally low wages and incomes. A classic case is that of the rice farmers. Leaders of the Pam-bansang Kilusang Magsasaka point out that the rice farmers produce *palay*, but like all other consumers they have to buy *rice* with very low income.

The 1982 FNRI survey show that the "nutritionally at-risk" households are those with seven or more members and headed by un-

skilled laborers, small fishermen and jobless persons. The survey noted quite aptly that it is not enough to grow more food crops if the poor and hungry consumers cannot afford to buy them.

Parasites Make Matters Worse

“Bulate” infections are so widespread among children that many parents consider this a normal part of growing up. In the context of the country’s malnutrition problem, however, parasites are not just a minor problem.

The uncontested leader of the pack is the ascaris — the white round intestinal worm. Infection comes easily, such as when children play with the soil, where the worm’s eggs abound.

About 85% to 90% of the population are infected with ascaris, according to Dr. Benjamin Cabrera of the University of the Philippines Institute of Public Health. By his count, the Philippines is No. 1 among Southeast Asian countries in terms of the prevalence of ascaris infection. Among developing countries, the Philippine rate is surpassed only by Iran, which registered a rate of 98%.

Cabrera estimates that the average 20 adult ascaris per person “steals” 2.8 grams of carbohydrates daily from the unwilling host’s small intestines. Given the largescale infection in the country, that translates into a daily food loss of about 50,000 kilograms of rice.¹³



The Scourge of 'Snail Fever'

In certain rural areas, an even more virulent form of parasitism is widespread: schistosomiasis or "snail fever."

An article in *World Health*, the WHO journal, described the plight of a snail fever victim.¹⁴

Roberto, a boy from Leyte, looked much older than his age and had all the symptoms of the disease. He was stunted, pale and emaciated, with an enlarged liver and spleen that gave him a big protruding belly. His stool sample contained viable eggs of the schistosome parasite.

The oldest son of a poor couple from the neighboring town of Santa Fe, Roberto left elementary school to help his father cultivate rice in the nearby fields to support a family of five younger brothers and sisters. Undoubtedly, it was there in the fields that he was frequently exposed to cercariae, the infective stage of the parasite.

The author, Dr. Bonifacio Dazo of WHO, estimates that some 700,000 Filipinos in 141 towns of 22 provinces suffer from schistosomiasis. Another four million are exposed to the risk of infection because they live near or use contaminated water. Snail fever afflicts mostly communities living near fresh water sources, where the snail carrying the parasitic worm thrives.

Schistosomiasis is seldom fatal. But the disease poses a serious problem because they usually affect agricultural, rice-producing and densely-populated areas. One of the most affected areas in Eastern Leyte which has about 100,000 cases. The annual loss due to disability caused among rural folk and the cost of treatment adds up to P250 million, according to Dr. Alfredo Santos, Jr. who heads the MOH schistosomiasis control and research service.¹⁵

WHO's Dazo was optimistic about the prospects of controlling snail fever, saying that the "outlook is bright." He noted that a growing number of the affected population are being treated with new drugs with less side effects.

The problem though is the conditions that make it easy for the disease to spread remain largely unchanged: the widespread lack of safe sources of potable water and adequate drainage systems. Clean water sources and latrines help check the spread of infection because these minimize people's contact with contaminated river water. These facilities also help break the cycle of the parasitic eggs spreading in water sources through the feces of infected persons.

The 'Rigodon' of Killer Diseases

There are two things striking about the country's morbidity and mortality patterns. The first is many of the diseases listed as the top causes of morbidity (which records the incidence of notifiable diseases reported to government institutions) are also found in the list of the leading causes of deaths (mortality patterns). (See Tables 1 & 2).

For example, 52% of diphtheria cases end fatally. Half of filariasis victims die. The figures for other diseases: tetanus 42%; H-fever 41%; pneumonias 39%; food poisoning 37%; cholera 32%; tuberculosis 26%; neoplasms or cancers 76%; and rabies 100%.

All of these diseases are preventable. There are in other words too many needless deaths, indicating that the health care system isn't intervening quickly and well enough to check diseases.

The second striking fact is the mortality patterns have not changed significantly for the past several decades. The top 10 killers now are practically the same group of diseases that were leading causes of death among Filipinos 30 years ago. One health educator described the situation as a "rigodon;" the only thing that changes is the ranking.

That the observation is worth bearing in mind in the light of how some government spokesmen occasionally try to read some positive significance into the rising incidence of heart diseases and cancers. They take that to mean that the Philippines is, well, "modernizing" because such degenerative diseases (in contrast to infectious diseases) are said to be a hallmark of developed societies.

Heart ailments for instance now rank as the No. 2 in the top 10 killers list, up from its No. 5 slot in 1969.

This interpretation of mortality patterns is probably misleading. It could be asked for instance whether a rise in the incidence of heart diseases is due to the fact that more of the heart ailments are being identified due to the proliferation of cardiologists.

Moreover, at least part of the increase can be accounted for by the increase in number of rheumatic heart disease (RHD) cases. RHD starts from a streptococcal infection commonly manifested as a "sore throat" that, when left untreated, affects the heart. It can be prevented by simply treating the sore throat before it spreads.

RHD is a disease of poor people who can't afford the drugs needed to treat sore throats. Matters become worse once a person gets RHD because treatment requires periodic penicillin shots for the rest of his life. Many RHD patients who can't afford such treatment deteriorate and suffer valvular complications.

As for cancers, the leading type today is lung cancer and can be attributed to widespread tobacco use. It's a problem many Third World

countries face. While the number of cigarette smokers is dropping in developed countries, partly because of strict controls on advertising and better health education, tobacco use is on the rise in developing countries, where governments generally do not impose restrictions on advertising.

Communicable Diseases Still Unchecked

Generally, though, the top killers are still communicable diseases, which are associated with poverty and inadequate social services. The drop in mortality rates for these diseases has been very slow in the postwar period. On the other hand, certain diseases, such as malaria and measles (which had been checked in the past) have been on the rise recently.

The classic poor man's disease is of course tuberculosis. In all its forms, TB is still the third highest cause of deaths, with a rate of about 61 deaths per 100,000 persons. Moreover, if we go by some health ministry ads, TB was ranked No. 2 in 1985.

What's significant about TB is that it persists to be a major killer despite decades of campaigns to check it. Dr. Angelina Arcilla Latonio of the Veterans Memorial Hospital for example said recently that the rate of decline of TB deaths has been "disappointing" for the past 10 years. In a report to the National Research Council of the Philippines, Latonio pointed out that though TB control started as early as 1900 the disease still ranks among the leading causes of deaths.¹⁶

Mental Health Under Growing Stress

It's the kind of story that sells tabloids. A laborer migrates to Manila looking for a job. After a few weeks of futile searching, his relatives in a slum area in the city tell him to get out of their house and stay elsewhere.

With his two-year old son in tow, the young man keeps on looking for work. But the boy cannot understand his father's mounting frustrations and one night cries incessantly due to hunger. The father blacks out and, in mindless fury, bangs his son's head on a concrete wall. The boy dies.

The MOH's tally of reported mental disorders has jumped in recent years. From 1978 to 1982, the ministry's Bureau of Health Services recorded only 9,584 new mental cases, excluding those handled by

private institutions. In 1983, the MOH listed 19,421 new cases or an increase of almost 200%.¹⁷

This phenomenal rise in the incidence of mental disorders has provoked a debate: is the jump due to an epidemic or simply the result of a more efficient detection method?

MOH doctors say it's the latter case. They point out that mental disorders are now included in the reportable diseases to the barangay health workers under the government's primary health care program. The health services bureau noted for example that even the inability to sleep or loss of appetite may be classified as slight mental disorders unlike in the past when acute mental cases are often the only ones recorded.

It's likely that such factors account for part of the increase in reported mental cases. But a case can also be made for the argument that worsening economic conditions and rising social and political tensions are taking a toll on the nation's mental health.

In a report to the WHO, Philippine Mental Health Association director Edita Martillano cited several factors that contributed to the rise of mental illness. These include: migration of rural folk to urban areas; overcrowding in slums; rising unemployment and worsening economic deprivation; deterioration of moral values and spirituality; breakdown in family ties; the export of workers to other countries resulting in more one-parent families; more women working outside the home; and the increase in population.¹⁸

Virtually all of these — mostly negative — trends have accelerated in recent years.

Current government estimates put the number of Filipinos suffering from some form of mental illness at 36 per 1,000. In absolute terms, that translates into about 990,000 mild and moderate mental cases and around 405,000 persons needing rehabilitation care.¹⁹

Inadequate facilities hamper the treatment of mental patients. NMH director Leonida Mariano said the country has some 150,000 cases needing hospital care, but the government has only 7,220 beds for them. The rest have to go to private institutions or be on their own.²⁰

Two-thirds of these beds are in Metro Manila and the rest are scattered in five regions. Curiously, the area with the highest number of mental patients (an average of 1,000) is Mariveles, Bataan — the site of the country's largest export processing zone.²¹

The poor state of the country's mental care system shows up in figures presented during the 1984 convention of the Philippine Psychiatric Association:

* About one-fifth of those who go to health centers suffer from some form of mental disorder, but may not be aware of it;

- * The roughly 15,000 botikas sa barangay of the MOH do not carry drugs for mental patients;
- * About 80% of the country's psychiatrists are in Metro Manila;
- * There are 55 psychiatrists in government hospitals nationwide, but only 18 of them are found in provincial hospitals.

The deteriorating situation is exemplified by the sad state of affairs at the NMH in Mandaluyong. In 1984, some 207 patients died at the state hospital over a period of six months. The health ministry launched an investigation after the news hit print. The official findings: the number of deaths, which were caused by an epidemic of gastrointestinal diseases, is only "slightly above normal."²²

The Health Hazards of Rising Social Tensions

The rising tensions generated by the country's economic, political and social crisis pose more direct, dramatic hazards to the nation's health than simply mental disorders.

The obvious manifestation of this is the mounting casualty count of both combatants and civilians in the civil wars ongoing between the government and both the New People's Army and Moro National Liberation Front.

Reliable overall figures are hard to come by. The figure of 50,000 is often quoted in tallying the casualty count in the fight between the armed forces and the MNLF up to the late 1970s. But that is about half a decade old. Hard data on the AFP-NPA are even more difficult to get. What are readily available are bits and pieces of what appears to be an increasingly alarming picture.

In Kalinga-Apayao, for instance, figures from the provincial health office show that as of 1985 gunshot wounds replaced malaria as the leading cause of death in that northern Luzon province.

Though it is difficult to assess the impact on civilians, it is clear that the government's counter-insurgency campaign, despite civic action projects that include free medical and dental clinics by army physicians and nurses, is adversely affecting larger and larger numbers of non-combatants as the scope of the conflict widens and its intensity heightens.

Of particular concern are the consequences on entire rural communities of such counter-insurgency moves as hamletting — the forcible relocation of farmers to designated places where they are concentrated and placed under control in the government's effort to isolate guerillas from their mass base.

While such measures predictably impose difficulties on the guerillas, they inflict even greater hardships on the displaced farmers and their families. The reconcentration centers are often congested, with little if any water and latrine facilities; they quickly become the breeding ground for various contagious diseases. Torn away from their land, the farmers are hard-up earning their livelihood, with predictable consequences on their families' nutrition.

Complementing hamletting are "food blockades," where the military controls the movement of food in rural areas to deny guerillas needed food supplies.

These measures have been resorted to at one time or another in Northern Luzon (particularly in the province of Isabela), the Bicol region, the island of Samar and various provinces of Mindanao. And they are likely to become more widespread as the civil war intensifies.

The Health Hazards of Development

Even much touted "development" programs are producing their own harvest of health hazards. One example is the case of schistosomiasis. The disease has exhibited in recent years rising prevalence rates. This disturbing trend, a reversal of the pattern of decline in prior years, has been shown to be associated with the construction of irrigation systems and large dams. These infrastructure projects have unwittingly produced better conditions for the breeding of snails which carry the disease.

Pollution is of course posing mounting dangers to both urban and rural populations. But there are two examples that illustrate most vividly how ill-conceived development programs can imperil the people's health.

The first is the Philippine Nuclear Power Plant in Morong, Bataan. Government assurances about the safety of the Westinghouse designed 620-megawatt pressurized water nuclear reactor have a hollow ring. And even if the plant, which is essentially of the same design as the Harrisburg reactor built by General Electric on Three-Mile Island were immune to the vagaries of possible earthquakes, volcanic eruptions and human error, there is still the unsolved problem of how to dispose of radioactive waste that will be produced by the plant every year.

The Morong reactor is adjacent to the most densely-populated area of the country. Metro Manila, with its six to seven million people, is just 50 or so miles away — within the danger zone in case of a critical nuclear accident.

The other example is the rising incidence of sexually transmitted diseases (STDs). This is a more roundabout problem. STDs are of course an old story. What is relatively new is how such diseases have been helped along dramatically by the growth of tourism. Aside from traditional sources such as vacationing American soldiers and sailors from Clark and Subic, the country's stock of venereal diseases are being replenished and upgraded by disease-carrying tourists, particularly those from the US, Western Europe and Japan.

This is related to the growth of prostitution, which tends to perk up with the influx of tourists, some of whom have helped create the demand for a new age-category of the oldest profession — child prostitution.

Hard figures are again difficult to come by. But the growth of the prostitution business overlaps the areas developed for tourism — Metro Manila, Baguio, Cebu and such formerly rustic places as Pagsangjan. This network serves as a channel for spreading STDs, both old (such as gonorrhea) and new (e.g. herpes).

What bears watching is the probability that AIDS may soon find its way to the Philippines. AIDS (Acquired Immune Deficiency Syndrome) is spreading rapidly in the United States and Europe where it first had infected some 15,000 people by 1985, about four years after the first cases were detected.

Caused by a virus that destroys the body's defense system, AIDS has so far remained incurable. Though it has struck mostly homosexuals, bisexuals and drug addicts, the disease has also hit heterosexuals and the suspicion is it is being transmitted among others through prostitutes.

Considering the extensive traffic of tourists and other travellers between the US and the Philippines, it is perhaps only a matter of time before the virus makes its debut in the country. And with the local prostitution network highly developed, the disease may find a ready mechanism for claiming its victims among Filipinos.



2

The Chronic Crisis of the Health Care System

by Michael L. Tan

A health care system has several types of facilities available for the population. The most obvious ones are hospitals, which are in turn divided into primary, secondary and tertiary levels. Primary level hospitals (which should be differentiated from primary health care) provide basic medical, pediatric, obstetric and gynecological services. Secondary level hospitals provide general surgery in addition to the services mentioned for the primary level. Finally, we have tertiary level hospitals, which provide specialized services. These tertiary hospitals vary in their approaches, depending on their classification as provincial or regional hospitals, where each of specialized services is handled by a particular department. The most sophisticated tertiary hospital are the medical centers, such as the Heart Center, where the entire institution is devoted to only one specialized field of medicine.

Besides hospitals, there are certain institutions such as sanatoria, which care for patients suffering from particular diseases like tuberculosis or leprosy. There are also mobile and semi-mobile units with services for endemic problems such as "social hygiene" (a euphemism for sexually-transmitted diseases), mental hygiene, dentistry, malaria, schistosomiasis, filariasis and malnutrition (e.g. nutriward units).

Finally, there are the facilities essential for primary health care, which in theory are designed to provide essential health services that are accessible, affordable and sustainable by the community. These would include rural health units and barangay health stations. The rural health units operate on a municipal level while, the barangay health stations serve the basic political unit, the barrio.

Table 4 gives a general overview of the number of health facilities in the Philippines. It should be pointed out that private sector participation is significant only in terms of hospitals. All other units are almost totally under the government.

For the purposes of our analysis of the health care system, we will discuss two broad categories — institutionalized care (mainly the hospitals) and primary health care (the rural health units and barangay health stations), together with other vital components such as nutrition, education and social services.

HOW WELL DO HOSPITALS SERVE THE PUBLIC?

"MYSTERY DEATH AT PGH" screamed the front-page headline of an afternoon tabloid last Sept. 29, 1984. An epileptic woman patient was allegedly mauled by security guards at the Philippine General Hospital, and then hauled into the "little morgue" — a room temporarily being used to supplement the "big morgue." The next morning, the woman was found dead. An investigation is still on-going.

Hospitals are not all that inhuman. Many provide exemplary service to the public. But it is also undeniable that the country's hospital system is a rich source of material on which tabloids thrive: horror stories and tragic tales.

The gold mines for such stories are the hospitals which serve the poor: government institutions and so-called charity wards in private hospitals.

A day of life and death at PGH

The first stop for most patients at the Philippine General Hospital (PGH) is the dispensary. As early as 6 a.m., hundreds of patients and their relatives start to queue for cards which will allow them to see a government physician. The heavy patient load has forced the hospital to set daily quotas. Many patients who are turned away are asked to return the next day. For those lucky enough to get a card, consultations start about 2:00 p.m.

Consultations are necessarily short, averaging about 15 minutes. Six to eight doctors share each consultation room. They also share one sphygmomanometer (blood-pressure equipment). There are no thermometers. "Hindi na uso yan sa PGH," one doctor remarks wryly. "We just write 'febrile' or 'non-febrile.'"

Another place to visit is the Emergency Room or ER. There, you get to appreciate the expression "sea of humanity," or rather "sea of suffering humanity."

After getting through security guards at the hospital gate, who insist on checking every visitor's bag, families are greeted by another bored security guard at the ER entrance, who waves them off to where the stretchers are. There aren't enough orderlies, so relatives often have to bring the patients into the consultation rooms themselves.



Who cares for “clinical specimens” in our hospitals?

There, patients are stripped, probed and interrogated. Anti-tetanus serum is given as a matter of routine because the risk of infection at the hospital itself is high.

Consultations and treatment are free of charge — but relatives have to pay for all the medical supplies, down to the last band-aid strips. Relatives run around, looking for a phone that works so they can raise money.

Patients may stay at the ER for a few hours or a few days. Dying patients languish while hospital departments debate whether they can still afford to take in another obviously hopeless case. There is a “Disaster Triage Area” next to ER, used only in large-scale emergencies. But you wonder if ER itself is a triage area, where physicians are thrust into the role of God and must choose who can still be saved.

Occasionally, a doctor screams at a nurse, or a nurse at an orderly, or an orderly at a patient. “You learn to be manhid (callous) at PGH,” a doctor says, apologetically. The hospitals personnel, like the patients, have to fight off frustration and anger in order to survive.

The budget paradox: too little is still too much

Lack of funds explains much of the hospital system's miserable state. Equipment and supplies, which are largely imported, have become more expensive. Hospital administrators say the prices of equipment and supplies doubled between 1983 and 1984. The health ministry said that between 1982 and 1984, drug prices rose by an average of 30 to 60 percent.¹

The financial dilemma of the hospital system is highlighted by the fact that the government already spends a disproportionately large share of its health budget on maintaining hospitals.

One-half of the health ministry's annual budget is allocated for the operational expenditures of state hospitals. Operating expenditures for just ten Metro Manila hospitals take up 10% of the Ministry's total outlay: Dr Jose Fabella Memorial, the National Children's Hospital, National Mental Hospital, National Orthopedic, San Lazaro Hospital, Dr. Jose R. Reyes Memorial Hospital, Ospital ng Bagong Lipunan, the Research Institute for Tropical Medicine, the Quirino Memorial General Hospital and the Rizal Medical Center. Not included are the cost of upkeep for the PGH, the Veterans Memorial Hospital, the Philippine Heart Center for Asia, Lungsod ng Kabataan, the Ospital ng Maynila, the Lung Center and the Kidney Center, which fall under other ministries and agencies.²

The hospitals' financial difficulties predate the current economic crisis. Back in 1980, the health ministry, in one of its rare moments of candor, admitted that several of its hospitals were sub-standard; these included three medical centers, one regional hospital, 17 tertiary provincial hospitals and 77 secondary emergency hospitals. Two years later, 80 percent of these hospitals were still considered sub-standard and the health minister revealed that funds set aside for hospital equipment for the budget year 1982 had been withheld by the budget ministry.³

Cost-saving versus life-saving

Matters have of course taken a turn for the worse due to the economic crisis. Hospitals — both government and private — have resorted to cost-saving measures which are bound to further cripple the delivery of health care services.

A health ministry directive issued in December 1983, for example, requires government hospitals to initiate cost-cutting measures such as the reduction of routine laboratory examinations and X-rays; conservation of water, power and fuel consumption; a freeze on the

hiring of new personnel and filling of vacant positions; reduction of the "variety of dishes served to patients and recycling unconsumed food"; cutdown in the use of office supplies; and a stop to the purchase of disposable medical supplies.⁴

Such cutbacks are taking a heavy toll on hospital services. At the National Orthopedic, for example, hospital workers report that it is not uncommon for two patients to share a bed and for the hospital not to have X-ray films and other essential supplies.

The Alliance of Health Workers (AHW), an organization of hospital employees fighting for economic benefits and upgrading of medical services, warns that the freeze on new hiring and replacements of hospital personnel is increasing the already bad patient-nurse ratio. Even before the crisis, a survey by the Philippine Nurses Association (PNA) showed that in some hospitals the nurse-patient ratio was 1:60.⁵

Not so for the rich

While the poor must content themselves with a rapidly deteriorating health care system, the affluent are not as disadvantaged.

Mr. de los Santos — industrialist, politician, philanthropist — has been having palpitations and has been advised to go to the hospital. The newsworthy event is picked up by local journalists. Mr. de los Santos chooses the Makati Medical Center, where he can be attended by a team of specialists.

He checks into an air-conditioned suite, complete with telephone, colored TV, refrigerator and a lounging area. A battery of diagnostic tests is administered: electrocardiograms, treadmills and the like. To be sure, the other organ systems are checked too. A little abdominal pain calls for a scan, just in case something is wrong with the liver. The scan alone costs P3,000.

But the tests are inconclusive and Mr. de los Santos transfers to the Heart Center. One of the diagnostic machines isn't working — they're waiting for spare parts and it'll take a month or two. He can't wait, so Mr. de los Santos flies off to Houston for a check-up. He takes along his family, his physicians, a nurse and his father confessor. In Houston, he finds tour groups catering to well-heeled Filipinos going for an executive check-up. A heart by-pass can be thrown into the package if needed. Mr. de los Santos makes sure that it's not one of those fly-by-night tour groups. His friends have advised him on whom to contact, to make sure he gets to see Dr. DeBakey or Dr. Cooley.



Mr. de los Santos passes the tests with flying colors and comes home a “new man.” He has one complaint though: “I went to Houston for expert American care and what do I find — Filipino doctors and Filipino nurses at every corner.”

This “parallel” health care system for the rich is still working, practically unaffected by the crisis. The questions though are: 1) how accessible are these services to ordinary Filipinos; and 2) what are the ultimate costs that must be paid to sustain this system?

The answer to the question on accessibility is obvious: the dividing line is the ability to pay. In a country where hepatitis is now a widespread disease, government doctors must rely on external visible symptoms to establish a diagnosis. But jaundice (the yellowing of the skin and mucous membranes), which is a clear sign of hepatitis, does not appear until the disease is already taking its toll. For those who can afford it, there is a reliable, early detection method — a liver profile test, which, unfortunately, costs ₱750 — most if not all of a month’s pay for many wage-earners.

The crisis notwithstanding, some private hospitals have even been able to expand their facilities. In 1985, the St. Luke’s Hospital and the Chinese General Hospital inaugurated new hospital sections with sophisticated diagnostic medical equipment.

The uneven trade-offs

The second question — what are the ultimate social costs — is trickier. Big outlays for hospitals and fancy equipment inevitably involve trade-offs. They are possible only at the cost of cutting back on other items. These cutbacks often hit services catering to the low-income groups — whose low paying power makes capital spending for their needs an “unprofitable” exercise.

So, while 80% of the country's radiation (X-ray) clinics continue to be rated by the health ministry as sub-standard, that same ministry at one time seriously considered buying a Nuclear Magnetic Resonance machine (NMR) at the cost of P25 million. Only a year before, the budget ministry had withheld P16 million intended to upgrade other more basic equipment in government hospitals.⁶

The cost of image-building

Public protests eventually pressured the health ministry to abandon its plan to buy an NMR. But the problem that the episode symbolized is hardly a dead issue.

Beyond the matter of adverse trade-offs that big-ticket spending on fancy equipment entails, the NMR case underscores the problem of *needless* spending associated mainly with image-building ventures.

Having one sophisticated machine seems to upgrade the image of the entire health care system. That kind of thinking would have ignored the fact that the machine's usefulness has been questioned even in the US.

On a larger scale, the construction of certain highly-specialized medical centers suffer from the same kind of misplaced priorities: the Heart Center, the Lung Center, the Kidney Center, the Lungsod ng Kabataan and the proposed Eye Referral Center, Brain and Trauma Centers, and an International Medical City in Tagaytay which the First Lady said would be a “premier educational center for medical students from all over the world.”⁷

The full construction costs for the Heart and Lung Center and the Lungsod ng Kabataan have never been made public. An audit of government institutions, only recently published, reveals that the costs of the land, building and equipment of the Lung Center amounted to P380 million, donated by the Philippine Charity Sweepstakes Office (PCSO).⁸

The costs of these institutions extend, of course, to maintenance and operation. These add up to a hefty sum, considering that the ultra-modern design of these centers involves such expenses as centralized air-conditioning and computerization. Again, funds are diverted from various sources.

In 1984, the 313-bed Lung Center was allocated P20 million from health ministry funds, while the nationwide tuberculosis program got only P9 million.

Similarly, the Lungsod ng Kabataan received a budget of P13 million from the human settlements ministry, while the National Children's Hospital was allocated P8.2 million from the health ministry.⁹

White elephants, anyone?

The most recent example of a white elephant is the Institute for the Rehabilitation of Man (IRM), which was founded by the First Lady. The institute was designed to "use love, science and art as instruments" to rehabilitate inmates from the National Mental Hospital, National Orthopedic Hospital and the prisons.

Its construction and maintenance has been supported with still unspecified sums supposedly squeezed out of budgets for the PC-INP, the social services and health ministries. As of early 1985, the IRM served about 40 patients. Meanwhile, over 4,000 patients at the NMH must grapple with congested living conditions and endure primitive electro-shock treatment instead of "love, science and art."

Casinos and Kidneys?

The Kidney Foundation Center is another expensive institution, whose funding source was not revealed until 1985, when opposition assemblyman Antonio Cuenco demanded an accounting of the revenues of PAGCOR (Philippine Amusement and Games Corporation), the government agency which runs the country's casinos. Cuenco discovered that P321 million had been disbursed from PAGCOR's funds to build the 50-bed Kidney Center which when he visited, had only 18 in-patients.¹⁰ Others remark sarcastically that late in 1984, the Kidney Center had only one patient, and had been closed to the public because that one patient's security was top priority.

Should hospitals be run like businesses?

That question should be asked given what has happened to the country's hospital system over the past 15 years.

Starting in the early 1970s, the number of private hospitals grew rapidly, from 430 in 1970 to 1199 in 1984. (Table 6) Government support was instrumental in fueling the initial rapid increase in the number of private hospitals. In November 1973, President Marcos set aside a P100-million fund to bankroll the construction of some 500 new private hospitals nationwide over a five-year period.¹¹

The idea was that private institutions would help fill the need for hospital services that state hospitals could not meet.

The rationale was, and is, appealing. The question though is whether that is a sound policy over the long term. Despite the laudable efforts of some institutions, private hospitals generally price their services with profits in mind, which means that such services are inaccessible for the bulk of the population. A number of hospitals are in fact listed among the top 2000 corporations in the country in terms of revenues and income: Medical Doctors, Inc., United Doctors Service Corp. (which manages Metropolitan Hospital), Cardinal Santos Memorial Hospital, Capitol Medical Center, Iloilo Doctors Hospital.¹²

The inherent, but often unperceived, dilemma posed by having a large part of the country's hospital system run on a profit basis became more dramatically evident when economic difficulties set in starting the late 1970s, and more so following the outbreak of the current Philippine debt crisis late in 1983.

Like most businesses, private hospitals are now plagued by rising operating costs and shrinking "markets." Costs are skyrocketing because these hospitals depend almost entirely on expensive imported equipment and supplies. Meanwhile, inflation has sapped people's ability to pay for high medical bills. In late 1984, members of the Private Hospitals Association of the Philippines said that their occupancy rates were running between 5% and 50%.

The predictable result: a rash of hospital closures. According to the PHAP, some 58 private hospitals folded up in 1984, while another 40 closed shop in 1985. Surviving institutions have taken retrenchment measures and the PHAP admits this has affected 25% of their personnel. A number of strikes have, in fact, been launched in several hospitals because of the tension between personnel, who need higher wages, and management, which claims that they have no money to raise salaries.¹³

Back in the government's lap

Caught in this crunch, private hospitals have appealed to government for support, including exemptions from tariffs on imported equipment, more loans and outright subsidies.

The government responded by putting up a ₱100-million fund for short-term "soft" loans to bail out distressed hospitals. The money comes from the State Insurance Fund and would allow hospitals to upgrade facilities and services.¹⁴

It remains to be seen, though, how far this help will meet the crisis of private hospitals. Reports in late 1985 indicate that some hospitals are defaulting on their loans from government banks. The PHAP says that four out of every five private hospitals are already operating on

borrowed money and that half of them are behind in their payments. As of November 1985, total borrowings of the hospitals amounted to ₱378 million, ₱256 million of which was owed to the government's Development Bank of the Philippines (DBP), with interest rates averaging 20% per annum.¹⁵

Some of these hospitals have already been foreclosed and passed on to be run by city governments. In other instances, city governments may not have the money to take over these hospitals, as in the case of the eight-story Holy Rosary Hospital and Medical Center in Tondo, Manila, catering mainly to low-income families in the area. The hospital was foreclosed in May 1985 by the Development Bank of the Philippines for debts amounting to ₱1.4 million, a relatively small sum which the city of Manila could not even afford.¹⁶

The point is that hospitals that are closing down are more often those which are patronized by low-income families. And the problem of rescuing these ailing hospitals falls back on the government, if it can afford to. Back to square one!

It is interesting that the consequences of the government's mismanagement in other sectors may even carry over into the health sector. The over-building of hotels in the mid-1970s, using government loans, is well-known. Several of these hotels eventually had to be foreclosed by the government. Now comes the news that the Hotel Enrico, foreclosed for defaulting on a loan from the Government Service Insurance System, (GSIS), will be leased to the Philippine General Hospital and converted into a dormitory for hospital staffers.¹⁷

The fetish over specialization

What has the government been doing with its own hospitals in the meantime?

The expansion and upgrading of government hospitals have been generally slow-paced. Studies show that the bulk of the state institutions were built before 1952. What the government has been building in recent years are highly specialized medical centers such as the Heart Center and Lung Center.

In contrast, more essential institutions such as the Quezon Institute and the National Mental Hospital have been getting the short-end of the budget.

As a result, the service capacity of government hospitals has been declining in recent years. Note that the number of hospital beds reached a peak of 45,161 in 1977 but has since dropped to 31,403 in 1984. This decrease took place even as the number of government hospitals increased (see Table 6).

Combining both government and private hospitals, the ratio of

hospital beds to the population — a rough measure of the system's capability to service the public — has barely improved over the past 15 years. At the end of the fiscal year 1969-1970, there were 11 hospital beds for every 10,000 Filipinos. This figure improved to an all-time high of 17.8 in 1977, but has since deteriorated. By the end of 1984, the figure was 13.2, one of the lowest in the last 15 years. (See Table 7)

Note that during this period, the number of private hospital beds took a greater share of the total. That means that the number of hospital beds available to more well-off sectors of the population increased. The losers were the poor who, for reasons largely of cost, rely mainly on government hospitals.

Why the Muslims should complain

What makes matters worse is that the few hospitals available are unevenly distributed in terms of location.

In the case of government hospitals, the distribution favors urban areas. Metro Manila, which has only 12.5% of the national population, claims nearly one-third of the government hospital beds as of 1983.

For the 12 other regions, the following have favorable shares of hospital beds in proportion to their population: Ilocos, Cagayan Valley, Eastern Visayas. These are the home regions of the most powerful political figures in the country.

All other regions are under-served in terms of hospital beds. The disparities are greatest for Muslim areas such as southern and central Mindanao (see Table 7).

SOCIAL SERVICES: THE COMMON PROBLEM OF NEGLECT

A health care system is actually embedded in a wider network of social services that directly and indirectly support health services. Water and sewerage system, housing, education and even infrastructure such as roads and communication networks are all important for health care.

But all these services are substandard in the Philippines and thus tend to worsen or complicate the country's health problems. Consider the following facts:

- Spending for social services has a low priority in the government budget. Total government expenditures for social infrastructure (schools, and health facilities) amounted to P4 billion from 1970 to 1983, only 4% of spending for all infrastructure projects. What's worse is that only 54.2% of pro-

posed social infrastructure projects were actually completed the lowest accomplishment rate among all infrastructure projects.¹⁸

- Education's share in the national budget has declined from an average of 25% in the 1960s to about 10% in the last decade.¹⁹
- The latest available data indicate that in 1980, only half of Filipino households had access to potable water supplies. The rest only on open wells, rain water and natural bodies of water.²⁰ It is not surprising then that water-borne diseases, mainly typhoid and dysenteries, account for many deaths yearly.
- Sewerage and toilet facilities are also inadequate. In Metro Manila, the "flying saucer" system (also known as the *balot* system) is still very much in vogue. Open dumping of wastes adds to the problem of pollution and contamination, greatly increasing the risks of epidemics.²¹



"Smokey Mountain" of Metro Manila: dumping site of garbage and breeding ground for diseases.

MEDICARE

Most countries have a state health insurance system to help shoulder medical expenses. In the Philippines, this takes the form of Medicare, patterned after its American namesake. But its critics say the Philippine version carries many of the defects of the American original and few of its strong points.

Created in 1969 by the Philippine Medical Act and later amended by Presidential Decree 1519, Medicare is administered by the Philippine Medical Care Commission, headed by the President's elder brother, Dr. Pacifico Marcos.

Seventy percent becomes twenty

The original set-up provided that Medicare should shoulder 70% of the medical costs, while the remaining 30% should be borne by the contributing member.

Current estimates show however that Medicare now covers only about 20% of medical costs for ordinary cases and 5% for serious cases.²² Even that reduced coverage is probably an over-estimate. The average benefits paid on Medicare claims is only about ₱206, hardly enough to cover even just standard professional fees.²³

Table 8 shows Medicare payments for various items, as provided for by Executive Order No. 949 issued in 1984. The executive order was issued to upgrade the benefits but the new amounts continue to be grossly inadequate. For instance, provisions for room and board in tertiary hospitals is only ₱30 a day while professional fees for major surgery have a maximum limit of ₱650, rates which are ridiculously inadequate. In 1985, the only amendment made for them benefits was to increase the allowances for sterilization: from ₱100 to ₱200 for a vasectomy and from ₱150 to ₱300 for a tubal ligation.²⁴

It should also be pointed out that until recently Medicare covered only in-patients. The problem here is that about 30% to 50% of people who seek consultations in hospitals do not have to be admitted as in-patients. These out-patients are not covered by Medicare. The system also does not provide for transportation expenses and does not cover certain services such as optometry, psychiatry and even normal birth delivery.

Where's the money going?

Medicare currently covers about 22.8 million (employees and their dependents). Only about 1.4 million have made claims.

Between 1972 and 1984, employees paid about ₱12.7 billion as mandatory contributions to the system. On the other hand, Medicare

has paid only ₱2.1 billion in claims during that period.

So, where is the money going? Part of it is going to investments. The total investment portfolio of Medicare as of the end of 1984 amounted to a staggering ₱1.1 billion.²⁵

In this sense, Medicare is operating like the Social Security System (SSS) and the Government Service Insurance System (GSIS). The entire social security system is seen by many as a set-up that benefits principally the agencies concerned, providing them with huge cash flows that may be tapped for unknown purposes. Their members meantime must bear with grossly inadequate benefits.

With such a situation, it is not surprising that various labor unions and organized groups have called for a moratorium on collections for the SSS, the Employees Compensation Commission, the Pag-ibig housing fund and Medicare. .

PRIMARY HEALTH CARE

Primary health care or PHC is one of the latest fads adopted by the government. This is not surprising since PHC has tremendous appeal: it has that attractive rural grassroots flavor that nicely counteracts growing public distaste for the government's propensity to build large, expensive, showcase medical centers that mainly benefit the affluent in urban areas.

So, it must be a great source of prestige for government to have its health minister Jesus Azurin receive, in May 1985, a World Health Organizations award in recognition, for among others, innovations in the promotion of primary health care in the Philippines. At the awarding ceremonies, Azurin announced that PHC now covers 99 percent of the population.²⁶

The facts however tell a different story on the government's implementation of PHC.

Down the totem pole

PHC is supposed to be the foundation of the country's health care system. It has two aspects: the traditional and the "modern". The traditional sub-system includes villages or folk practitioners such as the herbolario and the hilot. Government provides the modern or Western facilities, particularly through its rural health units (RHUs) and barangay health stations (BHS).

Only a few areas in the countryside are fortunate to have private health professionals who are willing to provide services at minimal cost. The murder of Bobby de la Paz in Samar shows how such selfless services can be misconstrued as subversive activity.

The record shows however that the government has dragged its

feet when it comes to building RHUs and BHSs (see Table 5).

The government started building RHUs in 1953 with funds from the United States. Subsequent laws passed in 1954, 1957 and 1963 provided for continuing funding for the construction of RHUs up to 1969. This network of RHUs has clearly been unable to cope with the needs of a growing population. In 1960-1961, it was estimated that one rural health unit covered some 20,743 people. By 1984, that figure had deteriorated to one unit for every 26,145 people.

The 1981 Ministry of Health National Survey showed that 40.4% of respondents were aware of an RHU and were living within a radius of 3 kilometers from such a facility. Another 24.7% lived within a radius of 3-9 kilometers and 8.2% lived outside of a 10 kilometer radius. Significantly, 26.7% of respondents did not give answers on the location of the RHU, suggesting that they were either not concerned, or unaware of the RHU.²⁷

Since most RHUs are located in the *poblacion* (town center), this effectively excludes the bulk of the rural population that live outside the town. Based on a 1976 study of the UP School of Economics, it was estimated that each RHU serves an area of only 28.3 sq. km.²⁸ Given 1,991 RHUs in 1985, the network's total service area nationwide would be only 560,345 sq. km. or about 28% of the total rural land area in the Philippines.

The unfilled gap in the barrios

The BHS is supposed to fill the gap that the RHU leaves in the scattered barangays or barrios. That however is not the case.

In 1976, the number of BHSs nationwide stood at 3,023. This figure went up to 7,353 in 1980 and then 7,991 in 1985 (Table 5). Though the number of BHSs has doubled over the past ten years, that is still less than one-fifth of the country's roughly 42,000 barangays.

Much of the increase over the past decade took place during the period 1975-1980. The drop in the number of stations built since 1980 is puzzling considering that in September 1981 the World Bank lent the Philippines \$22 million to build 990 new BHS over the next four years.²⁹

Using the peso-dollar exchange rate then, that meant that at least P177,000 could be allocated for building each of the 990 health stations, yet, only P58,000 was appropriated for each BHS. The balance of construction costs was supposed to be shouldered by the local community as their contribution in line with the principle of "self-reliance".

Not surprisingly, only 25 BHSs were built in 1982. The blame for the construction lag was pinned on the local communities, for failing to

put up their counterpart funds.³⁰ Progress has been non-existent since then — the health ministry's figures for the number of BHS in 1985 are exactly the same as that for 1984.

Under-staffed and under-equipped

The RHUs and BHSs in operation are almost always under-staffed and under-equipped. A 1975 World Bank report noted that:

Only about 500 of the approximately 1,500 RHUs occupy buildings designed for them, with the remainder in all-purpose municipal buildings or rented quarters.

A survey of RHUs done in preparation for a World Bank population loan found that many lack electricity and a potable water supply, and more than 90% had inadequate clinical equipment.³¹

The same World Bank report also noted problems with staffing, including low pay and the loading of RHU staffers with "sub-professional tasks."

Since then, there has apparently been little progress in this regard. And the problem can be linked to graft and corruption. Late in 1984, the World Bank released a report expressing dissatisfaction over the use of a loan extended to the Philippine government for its rural health program. The World Bank's performance audit team said that its \$25 million Population Project I loan, approved in 1974, had not been used as originally intended. Infrastructure was described as "over-designed, poorly maintained and under-utilized or utilized for purposes other than those intended under the project." The majority of RHUs had defects such as in plumbing and water supply and funds were unavailable for maintenance and repair.

The World Bank also reported that some P7 million worth of bank-financed equipment and supplies could not be adequately accounted for.³²

The World Bank's discoveries seem to have come rather late. As early as February 1979, eight of the 13 governors representing predominantly Muslim provinces in Mindanao had asked Marcos to probe discrepancies in the awarding of contracts of World Bank funded health centers in their areas. The governors reported that P11 million worth of contracts for region IX alone were awarded to a single Manila private contractor who abandoned the projects after being awarded the contracts.³³ Similar complaints were raised again in 1985 from concerned citizens in Surigao, all to no avail.³⁴

Health education: where it's going wrong

Health education, says the World Health Organization (WHO) is the cornerstone of primary health care. It is particularly important in the prevention of disease.

The two most important venues for health education are the schools and the mass media. Sadly, a lot of miseducation is taking place in both areas.

Let us take the schools. The critical area is elementary education, considering that almost half of Filipino children in the public school system drop out before reaching high school.

Until recently, health and physical education were integrated as one subject for elementary school children. A new revised curriculum now integrates health education with science subjects and there has been a noticeable, positive shift in the emphasis of health classes.

Under American influence, the stress in the past was on personal or individual sanitation, with teachers checking if the children used handkerchiefs or clipped their nails. This has changed. The school health guardian program now focuses on nutrition, family planning and drug abuse. Medicinal plants are also promoted through the program.³⁵



How well is health education integrated into schools?

55 doctors for 8 million students

Despite such changes, health education in schools still suffers from huge gaps.

First, the children's health habits are formed in very unhealthy surroundings. What is taught in school often clashes with what is actually done at home. Children are taught sanitation but live in slums without water or waste disposal.

More to the point is the insufficient number of health professionals within the school system, particularly the public sector.

To serve the country's 7.8 million public school children, the education ministry has provided only 100 positions for school physicians, 470 posts for dentists and 590 posts for nurses. These allocations were established in 1960, when the public school enrollment was only 3.9 million. The 1983 budget for school health services was fixed at only ₱1.65 million, or 22 centavos per student. The miserly budget and the consequent lack of adequate pay and other incentives have kept health professionals away from the public school system. At last count, only 55 of the 100 slots for school physicians have been filled.³⁶

The lack of teacher training

The second problem is the lack of training for the teachers themselves in health education.

Four universities, including the University of the Philippines and the Philippine Normal College, offer health education as a field of concentration for undergraduate education majors. But these courses are funded by miniscule budgets and attract few students.

The lack of trained health education personnel affects not only the schools but also mass health education campaigns. Older Filipinos remember that in the early postwar years, the government fielded mobile units in rural communities, offering lectures, films, posters and other printed materials on health care. Theaters regularly featured short documentaries on health in between movies. Such efforts have increasingly become a rarity.

“AKO”: How not to do education campaigns

The health ministry's “AKO” campaign in 1983 is a classic example of a poorly conceived mass health campaign. The acronym “AKO”, means “Ang Katawang Okey” (The OK body).

For a few weeks, some 280,000 “AKO” stickers were distributed to motorists and jeepney and bus drivers. The health ministry then saturated the mass media with print ads and radio/TV plugs explaining how to keep one's body “Okay”.

The commercials were bland at best and inane at worst. Movie personalities were shown, coming out from a shower or eating a nice full meal to project the need for sanitation and nutrition.

The campaign was heavily criticized for its unrealistic approaches and content, particularly when it was learned that the multi-media program cost ₱2.3 million, which is more than the budget for the public schools' health services.

Surveys conducted by the health ministry after the campaign showed that the AKO concept had little impact on the public. A few months later, the ministry began featuring another short TV plug — this time on "primary health care", pushing for cleaner surroundings and the cultivation of medicinal plants. Towards the end of 1985, a new series of plugs began appearing to promote public awareness of tuberculosis, immunization and childhood diseases. There has been no public reaction — favorable or unfavorable — perhaps because the ads have gone unnoticed.

It is not known how much these new ads cost. But these were probably funded out of the same source used for the AKO campaign: the ₱16 million information, education and communication component of a World Bank loan to the Philippine government.³⁷



Health bureaucrats: Out of touch?

The AKO campaign demonstrates just how badly out of touch the country's health bureaucracy is from the hard realities of the health situation. The health ministry is repeating the same mistakes committed by health education programs during the American colonial period. The Americans formed "knife and fork teams" to discourage eating with bare hands, a practice believed to be a major cause of disease. Later, the stress shifted to handkerchiefs, soap and nail-clipping. Today, we have glossy posters and stickers, radio and TV spots that repeat the tired old themes of "keep your surroundings clean" along with some new ones like "avoid drugs" or "plan your family." These messages ignore the deeper causes of filthy environments, of drug abuse and malnutrition.

Health workers who join community-based programs have learned the hard way how people react to such messages: "We know what to eat," they say. "And we know what to do to avoid and cure diseases. Our problem is finding the means to buy nutritious food, or to build a safe water supply or to buy needed medicine."

No match for business commercials

Finally, it should be pointed out that, while health education campaigns do have some intrinsic value, the fact is they are overwhelmed by heavily-funded promotions, by business firms, of cigarettes, alcoholic drinks, infant formulas and useless drugs.

In many instances, companies even exploit health education campaigns to push their products. The crudest form of such dubious health education is TV shows and spots that feature "experts", particularly foreigners, endorsing everything from toothpaste to pain-killers.

IMMUNIZATION: HAMSTRUNG BY AN OVERDOSE OF BUREAUCRACY

The World Health Organization estimates that 87,000 Filipinos of all ages dies each year from neonatal tetanus, measles and pertussis. These three diseases, together with diphtheria, tuberculosis and poliomyelitis are among the leading causes of death among Filipino children.³⁸

The tragedy is these children need not die. All these diseases can be prevented through immunization and are, in fact, the target of global efforts by the World Health Organization and the UNICEF in their Expanded Program of Immunization (EPI). Pregnant mothers are also covered by the Program because they face greater risks of contracting tetanus.

The government's immunization program however, suffers from many deficiencies. For example, a presidential decree actually makes it mandatory for children to be immunized against tuberculosis. But, in fact, many children do not receive their BCG shots until the age of seven, when they enter elementary schools. This protection comes quite late.

The record for vaccinations against other diseases is even more depressing and indicates poor coverage by government health personnel. There are, for example, only two such rounds of vaccination by the government each year: during the months of January and June.

The most recent figures from the Philippine government on immunization coverage of infants are not very encouraging: 76 percent for tuberculosis, 61 percent for DPT (Diphtheria-Pertussis-Tetanus), 58 percent for measles.³⁹

Turning children into NPAs

Government personnel often blame the poor for their reluctance to bring their children for vaccination. This is a real problem. In the larger context, this reflects the failure of health education, not only to explain the benefits of immunization but also to clarify that there may be some minor side-effects, such as fever.

Another significant obstacle to an effective immunization program is government bureaucracy.

While they recognize that their personnel cannot cover a large part of the target population, many health bureaucrats are still unwilling to train and mobilize village health workers to give the shots.

In one instance, local government officials and the military went to the extent of warning villagers in a northern Luzon province not to join a non-governmental organization's BCG vaccination campaign which tried to tap community health organizers. The officials claimed that the vaccines would turn the farmer's children into NPA guerillas. The funny thing is that the vaccines had come from the government's own laboratories.

Heavy dependence on donations of foreign-made vaccines

The Philippines is still heavily dependent on imported vaccines, BCG being the only vaccine produced locally. The bulk of vaccine supplies are donations of UNICEF and Rotary International, a dependence which can be dangerous since donations can be reduced or stopped at any time.

There are efforts to develop local vaccines, but this will take time. Even BCG production, which has been going on for a number of years, has not been perfected. The local vaccines tend to leave larger scars than the imported versions. This problem relates to a wider one of science and technology being given low priority in the country, in terms of support for research and development.

Steep prices for private immunizations

People who opt to have the shots given by private doctors have to pay steep prices, not only because of the physician's fees but also because of the high cost of imported vaccines.

For a complete round of immunizations against the six top childhood illnesses, a family would have to shell out as much as P200 for the vaccines alone.

Immunization is important not only for children and pregnant women. Hepatitis, for example, is endemic in the country. But it costs P1,800 for a complete round of shots. Rabies is another serious problem, the Philippines having one of the highest death rate in the world for this disease. Yet the vaccines, which are imported, are extremely expensive. A French human diploid vaccine costs P1,000 for each dose, the standard treatment running through six doses.



NUTRITION: ARE YOU MAL-NO-RICED?

Good nutrition is often the best defense against disease. It is also vital in determining a patient's ability to recover from disease. The chances of an under-nourished child dying from various childhood diseases such as measles have been shown to be much higher than if the child were of normal weight.⁴⁰

The prevalence of malnutrition and avitaminoses in the country as discussed elsewhere in this book goes a long way in explaining the poor health situation of many Filipinos.

Given such a situation, what is being done?

Still barking up the wrong tree

Nutrition programs in the country lean heavily toward rehabilitation, i.e. they are curative, not preventive, in orientation. On the surface, the nutrition agencies also pay attention to mass nutrition education. But the few education materials that are produced are not widely disseminated, and are easily overwhelmed by the numerous ads for all sorts of junk food.

Bureaucratic squabbling: endemic among nutrition agencies

Part of the problem comes from the intense squabbling and politicking among the various offices and agencies involved in the nutrition program. The National Nutrition Council (NNC), under the office of the President, was set up to be the umbrella group for the different government ministries' nutrition programs. But the NNC appears to be unable to keep friction under check perhaps because there are numerous overlapping functions among the different agencies.

The NNC is housed in the same building as the Nutrition Center of the Philippines (NCP), as a quasi-private concern headed by the First Lady. But people familiar with the nutrition set-up say that the worst insult for someone working with the NCP is to be asked if he or she is working for the NNC.

Agencies that must deal with the NNC and NCP include the Food and Nutrition Research Institute (under the National Science and Technology Authority), the National Nutrition Service (under the health ministry) and various agencies under the wing of the ministries of social services, education and agriculture.

The bureaucracy here is immense; intrigues over funding and jurisdiction intense.

Moreover, the poor state of nutrition in the country, despite the much publicized nutrition rehabilitation efforts, puts these agencies under great pressure. Politically unacceptable data on malnutrition is zealously guarded and may even be revised, as pointed on in the appendix to this book where health statistics are explained.

Rehabilitation efforts: piecemeal and fragmented

Present nutrition rehabilitation efforts are directed mainly at children. But the approach is piecemeal and fragmented, with overlapping functions and projects among the different agencies.

There is, for example, the "nutri-ward" approach. Severely undernourished children are put through an intensive feeding program and bombarded with mental stimuli. Such efforts are admirable and the heavy publicity given them give a picture of a holistic approach. The fact remains though that only a few children are rehabilitated in such centers. These children are kept in these wards only for several weeks, after which they are sent back to their impoverished environments, where malnutrition is ready to strike again within a few weeks.

One former government nutritionist describes other experiences in the rehabilitation efforts, some of which could almost be considered funny were it not for the fact that lives are at stake. These include

villages whose children are surveyed four or five times by personnel from different government nutrition agencies, who then disappear with the data. Those that do return bring stale "nutribuns", which villages call "nutri-amag" (nutri-molds).

One rehabilitation project should be highlighted for its questionable value. Vitamin A deficiency is a big problem among Filipino children and from 1979 to 1981 the NCP launched a Vitamin A fortification project in pilot areas. Vitamin A supplements were delivered through enriched monosodium glutamate (MSG), better known as *vetsin*. Supplies were provided by the Japanese company Union-Ajinomoto, the largest *vetsin* manufacturer in the country.⁴¹

The catch though is that MSG has been documented to produce harmful side-effects and the children are much more susceptible to such problems.

Advocates of the *vetsin* program say there is no safety problem and that MSG was chosen because it is popular among Filipino housewives. Many consumer groups, here and abroad, are, however, opposed to the massive promotion of *vetsin*, not only because of its potential toxic effects, but also because its "flavor-enhancing" quality is one way of obscuring food inadequacy.

Suspensions that *vetsin* manufacturers have their interests in the Vitamin A fortification project stem from consumer groups' larger concern over the power of big business and its implications for public health. Another case in point is the heavy advertising pushing products that further erode the already meager food budgets of many Filipinos. Infant formulas, often promoted at the expense of breast-feeding, take up from one-third to one-half of the income of minimum wage earners, according to various estimates.⁴²

Soft drinks and all sorts of junk food also pose a problem. Filipinos, like many people in developing countries, are heavy consumers of Coke, Pepsi and 7-Up. Soft drinks companies, largely controlled by multinationals, pour huge sums into high-powered ad campaigns such as Pepsi's "taste challenges."

No stone is left unturned in these bruising ad wars between the two cola drinks. One will notice that even the nutri-buses of the Nutrition Center, which tour the country dispensing nutrition information, carry the stenciled promo: "Donated by the Coca-Cola Bottling Co."

Tied-in US aid: dubious generosity

Feeding programs have been started in public schools, using food donated by the US government under Public Law 480. The PL 480 program has been criticized as an example of aid that hurts more than it helps: it is a rich source of graft and corruption and, worse, makes recipients dependent on such sources.

It is interesting that the Philippine government has recognized the program's political implications: by accepting such aid, the country falls into the category of "basket-case" countries where hunger is endemic. So, in 1983, the government decided it would phase-out such aid in order to build "self-reliance." The move anticipated the US supposedly because malnutrition would no longer be a problem in the Philippines.

The phase-out was however opposed by various sectors, including some government officials. The decision has since been reconsidered by both governments. In fact, added food aid for the Philippines was approved by the US Congress in 1984 due to the current economic crisis. This lumped the Philippines with the famine-stricken countries of Africa.⁴³

THE POPULATION CONTROL PROGRAM: MORE BUREAUCRATIC SQUABBLING

There is still much debate over the Philippines' population control program. With the country's population estimated at almost 56 million by the end of 1985, it is difficult not to recognize that there are real pressures posed by the growing number of Filipinos. At the same time, the country's poverty has also been pointed out as a function of maldistribution of abundant resources, that the country can support a large population without having 70% of the population living below the poverty threshold.⁴⁴

Whatever the arguments may be, family planning is considered vital in any health care system. It is important in terms of assuring better maternal and child care; obviously, a mother who has one child each year is not going to be able to give the same quality of care to her children as in cases where the children are spaced three or four years apart.

The Philippine government claims to have a strong family planning program, supposedly using a "cafeteria approach" wherein people are given the choice in family planning methods. Critics however say that the government program tends to be manipulative and that the main target — women — are not adequately informed on the advantages and disadvantages of the various methods: oral contraceptives, intra-uterine devices (IUDs), injectable contraceptives (including the controversial Depo-Provera) and sterilization. The experimental Norplant, which involves the implantation of a slow-release hormonal preparation that suppresses ovulation for three to five years (as against three months for Depo-Provera), is also being used on an experimental basis by government hospitals.⁴⁵

The government itself is beginning to admit that progress in their program has been slow. The problem is that their program involves more of population control, with people perceived as passive “acceptors” of family planning methods. Interviews with people formerly connected with government population control agencies reveal that the whole program is too goal-oriented: targets and quotas on acceptors, with incentives given for exceeding these quotas have resulted in doctoring of statistics by family planning “motivators”.

The pressure to present good “achievement rates” is due to the fact that the programs are mainly funded by US loans and grants. Still another factor is that there are a number of population agencies whose functions overlap, much like in the nutrition programs.

These deficiencies have accumulated through the years and in a recent evaluation of the programs, the World Bank expressed alarm over “ambiguity” in the national population policy. They noted minimal progress in “fertility reduction” and suggested reorganization in the bureaucracy. The World Bank observed that the Commission on Population (POPCOM) was too often “influenced by strong personalities and special interests represented on the board”, and that it was not effectively linked to the health ministry, which should, strictly speaking, be the main implementor of the family planning programs. Besides POPCOM, there is a “quasi-private” organization called the Population Center Foundation (PCF) headed by the First Lady.



Population Control As Tied-in Aid

There is big money in population control, as academicians well know. To get funding for research, anything on population control can be a real bonanza. The bulk of USAID money for “health” for instance is actually meant for population control. World Bank loans are also similarly oriented; in fact, the loans incurred by the health ministry have been mainly for population control on which interest payments can come up to a hefty sum.

A study published recently by the National Economic and Development Authority (NEDA) zeroes in on an interesting case of tied-in aid — the Population Planning III project funded by the USAID. The project involves \$27 million loans and \$30 million in grants and was awarded to POPCOM, but the agreement on this project specifically states that \$20 million of the loan proceeds was to be used for the importation of contraceptives. To the credit of the Philippine government, negotiations were attempted on this issue. In 1983, the government actually turned down \$4.5 million that was scheduled to be released by USAID because of an excessively high inventory of pills and condoms. The government also wanted a moratorium on the use of intra-uterine devices (IUD) pending a review by POPCOM on the IUD's status as an abortifacient.⁴⁶

The issue of population control again reflects the need to examine health concerns from all perspectives, including the aspect of the First World imposing its decisions on the Third World.

TRADITIONAL MEDICINE: THE UNTAPPED RESOURCE

When President Marcos dropped out of public view on several occasions starting August 1983, rumors were rife that he was seriously ill. He subsequently confirmed that he had a prolonged bout with a severe case of allergy, pain from old war wounds and a still unknown-unidentified virus. Before that disclosure, the talk was that he had undergone various kinds of treatment — from a kidney transplant to heart surgery. The grapevine also mentioned that he had been treated by psychic surgeons — faith healers — in Baguio.

True or not, that last item serves as a dramatic reminder that a description of health care in this country would be incomplete without referring to traditional medicine.

Traditional medicine in the Philippines represents a pool of resources with great potential. It is based on folk knowledge, passed on from generation to generation and includes both beliefs and practices about health and illness. Despite the world renown that some Filipino faith healers have won, folk medicine remains largely untapped, kept at the periphery of the country's health care system, thus denying the people of its full benefits.



Herbal medicine: no lack of plants

Herbal medicine is a good example of useful folk medical wisdom. Nearly every Filipino is familiar with a few plants with medical value, rural villagers having a wider range of natural medicines at their disposal. The number of medicinal plants used by different groups of Filipinos is staggering. One computerized review of published studies done by AKAP in 1979 produced a list of 1,278 different medicinal plants, about 10% of the total number of plants known to exist in the country.⁴⁷

The uses of these plants, either singly or in mixtures, are based on a variety of beliefs, some empirical, others magico-religious in nature. Traditional medical beliefs are eclectic, drawing from many sources, including Western medicine. So, it should not be surprising to see traditional concepts of "hot" and "cold" extended to the use of Western drugs such as antibiotics.

Traditional medical practitioners form another great resource. A 1983 WHO report estimates that the Philippines has about 40,000 *hilots* (traditional birth attendants), 100,000 *herbolarios* (herbalists) and an unspecified number of other practitioners such as the *manghihilot* (bone-setters) and a variety of magico-religious practitioners



Medicinal plants offer viable alternatives to high-cost western drugs.

like the highly-publicized faith healers.⁴⁸ There are also a number of “specialists” like those who concentrate on tooth extractions or removing fish bones stuck in the throat. Most of these practitioners are part-time healers, often coming from the ranks of their fellow villagers.

The first choice because there's often no choice

The popularity of traditional practitioners can be quite high. For example, latest estimates from the health ministry indicate that almost 40% of total childbirths are still attended by the *hilot*. This figure goes as high as 70% in many rural areas.⁴⁹

There are various reasons why Filipinos continue to rely heavily on the traditional medical system. One obvious reason is cost. Medicinal plants are cheap alternatives to high-priced drugs from the botica (drugstore). Many villagers maintain backyard boticas, growing the more commonly-used herbal plants. Also, traditional medical practitioners charge little, if any, fees. With the current economic crisis, one can expect that the traditional medical system will take on added importance.

Another factor is the cultural importance of traditional medicine. Western concepts of health and illness remain alien to many Filipinos. “Germs” are inadequate explanations for many diseases and traditional theories provide alternative answers, citing psychological, emo-

tional, social and even political factors in explaining disease. Man's relationship with nature and the supernatural also figure prominently in these theories.

Government policy: ambivalence and neglect

Some developing countries, notably China, have made it a national policy to take full advantage of the useful aspects of the traditional system to deal with their immense health problems.

Official policy in the Philippines, however, remains ambivalent and half-hearted, apparently reflecting the diverse vested interests at work within the country's health care system.

Medicinal plants, for example, are being promoted by the health ministry, and some research is being done in this area. But critics observe that research is going too slowly and that dubious commercial motives have entered the picture. There is talk, for one, about the export potential of local herbs; this is apparently an attempt to cash in on the fact that many Western drugs use herbal ingredients in response to the demand for "natural" products in Western countries. The danger here is that such concerns may sidetrack more important efforts to make low-cost herbal preparations more widely available to poor Filipinos.

Currently, most of the herbal medicines being promoted by the government are still crude preparations and there are still no viable substitutes for antibiotics, which are vital in controlling endemic communicable diseases.

Traditional healers on the other hand have been largely ignored by the government. One exception appears to be traditional midwives. Some of them have been trained for village maternal and child care work, and for family planning. Other traditional practitioners, such as herbalists and bone-setters, have for the most part been ignored.

Double-Standards still at work

The psychic surgeons are however another story. Charismatic persons, some of these psychic surgeons have developed large clienteles that include foreigners from the US, Canada and Europe.

Their extraordinary services fill a market demand for treatment of desperately ill individuals. Exorbitant fees are sometimes charged and some of these healers have amassed large fortunes that are invested in "clinics", hotels and "health resorts." Some also have powerful patrons in the government. This has elevated them to high social status.

It seems, therefore, that even traditional medicine has been rent by the kind of inequalities and divisions that mark the rest of society. On one hand, there is a mass of village practitioners that remain largely

ignored by government, and shunned by the "legitimate" medical practitioners. On the other, there are the urban-based faith healers who amass wealth from their wealthy clients. One of them, Ramon Labo, even ran (but was defeated) in the 1984 parliamentary elections under the ruling KBL.

SYNTHESIS

Paano naman iyung anak ko, dinala ko diyan sa puericulture center pero hindi pa siya grabe. Sa puericulture center, tinuro ako kung saan saan. Sige doon ka aniya doon ka. Hindi kami pinapansin kaya sa inis ko, pumunta na ako sa ospital. Sa ospital naman, tinatanong ako kung may pera ka ba dahil wala pa nga akong card. ₱2.50 ang bayaran para sa card pero pipiso lang yata ang dala ko noon. Ngayon, hindi ko na napatingnan ang bata dahil wala akong pera. Kung ganoon, grabe na ang anak ko, kaya dinala ko sa isang doktor, pero wala na rin siyang magagawa. Kailangan daw ng gamot, pero wala kaming pera para sa pansaksak ng tubig (dextrose). Nakahiram ako ng pera at pina-dextrose nga siya, pero wala rin.

(My child's condition still wasn't serious when I brought her to the puericulture center. There, I was given the run-around, referred from one place to another. We weren't being given attention and so we went to the hospital. There, they asked me if I had money because I had to pay for a "card" (admission chart). The card was ₱2.50 but I think I only had one peso with me. So, the child wasn't examined since I didn't have the money. And her situation became more serious. When I brought her to a doctor, there was nothing they could do. We were told to purchase drugs, but we didn't have the money for the dextrose. I was able to borrow some money for the dextrose but by then, the child was gone.)

— A mother from an urban slum community (Las Piñas) who lost her child.

Stories like the above have become more and more common. A few make it to the papers, such as the much-publicized 1983 case of Alan Foronda, the child of a newspaper photographer. Alan died after his parents shuttled from one hospital to another; each time, they were turned away because they did not have the money to pay an admission deposit. Such deposits are actually illegal but the law is apparently not being enforced.

The issue of admission fees is only part of the bigger problem, of a health care system which is clearly malfunctioning. Hospital administrators claim that they have to make profits to keep going, and point out that absconding patients account for huge losses in their hospitals. But most Filipinos live below the poverty line, and obviously cannot even afford the smallest of admissions deposits, much less the other health care costs. With the economic situation deteriorating, the number of people in such a fix seems to be increasing. Some physicians in government hospitals note that they are getting fewer patients from low-income groups and more from the middle-income groups, the "new poor". Apparently, the "old poor" now cannot even afford the government hospitals, which require patients to pay for every drug and medical item used.

Some observers from the business sector say the problem is that Filipinos do not plan for medical emergencies. Figures from the National Census and Statistics Office (NCSO) indicate that on the average, about 1.7% of Filipino family expenditures goes to medical care, compared with about 4.8% for alcohol and tobacco.⁵⁰ To some extent then, we have to recognize that there is some distortion in consumption priorities, but this takes us back to the role of indiscriminate advertising by alcohol and tobacco manufacturers, compared with minimal efforts at health education.

One also has to recognize that low income levels, in general, determine the low expenditures for medical care. The Center for Research and Communication says that higher yearly incomes also mean increasing budgetary shares for medical care. Significantly, there is evidence to show that improvements in the over-all health situation, such as a drop in infant mortality, increases the demand for health services.⁵¹

Another way of looking at the situation is to put the blame on the lack of social conscience or plain humanitarianism among physicians, many of whom are also hospital owners. There is no way of evading this issue, since there can be no justification for people dying simply because they could not afford the fees of private physicians or hospitals. It is always distressing to see physicians who have made their fortunes by specializing in adding an extra eyelid on women who do not like their "chinita eyes", while thousands of Filipino children go blind from malnutrition. The economic problems of health professionals are undoubtedly real, and this is discussed in another chapter, but returning to basics, the question that remains is this: can health continue to be considered a commodity, particularly in the context of an under-developed country like the Philippines?

Evidently, national government planners seem to think so. There is an apparent trend towards encouraging the private sector to expand

in the health field, on the very dubious assumption that health care can improve by allowing the interplay of "free" market forces. Even within the government sector, there is a move in this direction, this time in the guise of promoting "self-reliance".

The National Economic and Development Authority (NEDA)'s updated 5-year development plan calls for an "efficient management of resources" in government health institutions by encouraging the use of "income from laboratory, hospital, medical exam and other such services . . . Likewise, in the long term, proceeds from the sale of herbal medicines will be an additional source of income."⁵² One can therefore predict continuing budgetary reductions for health in the future, while government health institutions generate income by charging their clients.

Amid these calls for efficient resource management, we are still left with the continuing problems of government mismanagement, graft and corruption. Certainly, compared with other government agencies, the health ministry has a fairly clean record although few cases have surfaced, as with the anomalies connected with the World Bank loan, cited earlier. But even graft and corruption in other government agencies have their effects on public health. Consider, for instance, the case of the Quezon City government's release of P1.9 million for drug purchases in 1983, with an audit revealing that only P900,000 of that amount was used to buy the drugs.⁵³ Few government institutions seem to have been spared from such forms of corruption, one which has reached epidemic and institutionalized proportions.

Reorganization of government agencies takes place periodically, each time supposedly to "rationalize" operations so that activities can be accomplished more efficiently. The health ministry is no exception, the latest restructuring taking place in 1983. Each restructuring is marked by jockeying and intrigues as positions in the political constellation change. As has been described for the nutrition program, "rationalization" is a myth. Fragmentation, in-fighting and sectarianism continue to plague the health agencies, at the cost of the public's welfare.

The bureaucracy is also notorious for its irrational policies. In 1983, valuable drugs in a provincial hospital in Ifugao were reportedly expiring but could not be released because there was no physician to authorize its distribution.⁵⁴ Certainly, the health ministry is not the only government institution with such red tape, but since it deals with health, a matter of life and death, such bureaucratic mazes can be infuriating.

In recent years, there has been an added plague on the bureaucracy. We refer here to the increasing concentration of power in the

Ministry of Human Settlements and the Metro Manila Commission, agencies headed by the First Lady. Again under the guise of developing "total" and "integrated" approaches, these agencies have usurped control over numerous projects from food production to education and health. The Lung Center of the Philippines is a case in point. Although it obtains part of its funding from the health ministry's budget, the Lung Center is under the jurisdiction of the Ministry of Human Settlements.

The Human Settlements Development Corporation, under the ministry of human settlements, in fact manages several other government hospitals and apparently, these are operating as losing corporations. In 1983, the following losses were reported for hospitals operated by the HSDC: ₱51.9 million for the Philippine Heart Center, ₱11.1 million for the Lung Center and ₱15.3 million for the Lungsod ng Kabataan.⁵⁵

The issue here is not just a matter of white elephant edifices, but also the use of the already scarce health resources for purposes which are often political in nature, such as the heavily publicized, but useless dole-out projects like CIVAC medical missions, MARCOS (Medical Assistance to Rural Communities and Other Sectors) and IMELDA (Integrated Medical Expeditions to Less Developed Areas). The motives of IMELDAs have become so obvious that rural people refer to the project as "Intensified Military Exploitation of Less Developed Areas" because the expeditions are frequently launched as part of the military's counter-insurgency efforts.

As for encouraging private sector participation, we should recognize that there is no lack of NGOs in the health field. There are numerous Catholic, Protestant and non-sectarian groups working in programs related to health, nutrition and population. For instance, there are at least 39 NGOs (in addition to 78 government agencies) dealing with mental health alone.

Many of these NGOs cling to anticipated (but politically secure) "charity" orientations that launch occasional free clinics, with few lasting effects or changes. Those that try to bring about deeper transformations in the health situation and the health care system run the risk of government harassment and intimidation, as shown by the cases of Bobby de la Paz and other health workers. Obviously, private initiatives are not encouraged unless they serve the existing political order's interests, whether in terms of giving palliatives, or in glorifying the government's political image.

Economists use the term "elasticity" to describe the dynamics between supply and demand. Health care is said to be relatively inelastic, that is, even as prices rise, the demand does not decrease as quickly. Within certain limits, people are willing to pay for quality



Are there choices in health care for medical indigents?

health care. This is perhaps best exemplified by the fact that right across the street from the Philippine General Hospital, said to be the Philippines' best government hospital, are numerous private clinics, many operated by physicians from the PGH. Clients who are not satisfied with PGH's facilities, and apparently there are many, can still pay for the expertise of PGH's physicians, in a private clinic, where facilities may be more reliable, but with correspondingly higher fees.

Yet, we find more and more people left out, even from the government's subsidized health care system. The government has turned its back on its responsibilities of providing decent health care, mainly through two excuses. One is that they are now implementing "primary health care" — thus, the Quezon Institute phase-out was supposed to represent a shift towards domiciliary and community-based care of TB patients, but there are no funds for this shift.

The other excuse the government uses is that it is now trying to encourage private initiative. Yet, few measures are taken to assure that certain standards are maintained — reasonable professional fees and ethical medical practice, for instance, in order to assure the public a real freedom of choice between the private and the public sectors, without jeopardizing the right to health. It is also this obvious commitment to "free enterprise" which explains the general lack of



Double standards in health care — who suffer the most?

“political will” to improve the quality of other social services, and to formulate and enforce laws related to environmental protection and occupational safety.

All is not lost for scores of medical graduates who fail to pass the medical board examinations and who have since been barred from the practice of medicine.

Parliamentary Bill No. 117 would allow them, under special license, to practice in the rural areas. The bill, drafted by Assemblywoman Carmencita O. Reyes, would in effect make use of idle but trained medical manpower who, by technically, are disqualified to practice. . .

Members of the Batasan committee on health, who endorsed the Reyes bill, said this is one way the government can recover its investment in the education of medical graduates.

Times Journal, August 2, 1980

The bill fortunately, was not passed; but the mere fact that it was proposed, and endorsed, reflects the state of the health care system in the Philippines. It is a situation where the poor, as represented by the rural population, is seen as inconsequential, entitled only to inferior health care.

What seems to be in force today is the “inverse care law” first described in 1971 in a British medical journal: “Those in the greatest need of medical care have the poorest access to it.”⁵⁶ That this “law” continues to govern is an indictment of an entire socio-political system’s failure.

The Mishaps of Medical Education

Or How to Produce Too Many Doctors
And Still End Up With Too Few

by Esperanza Cabral, M.D.

Dear Dr. Cabral:

I am a fourth-year medical student in one of the medical schools that you have been referring to in your columns. In a few months, I am going to be an M.D. I feel like I've been on a train careering about in a long tunnel. Now that the ride is almost through, the dim light that I was beginning to see at the end seems to have been shut off.

I used to love my pediatrician, as did every other kid who attended his clinic. He had shoes I wanted to step into, if you know what I mean. My childhood ambition was fed by my Mom and Dad and zillions of doting aunts and uncles who kept reminding me how highly-regarded doctors are and how it was their dream to have one of their own in the family.

I studied hard and made it to the U.P. for pre-med, and there I found out how many other hard-working and intelligent students who wanted to be doctors there were. By the time I was in third year pre-med, I already suspected that there were at least 140 of them who work harder and are more intelligent than me. In fact, there were a few hundred more that I failed to take into account, because not only was I not accepted at the U.P. College of Medicine, I was also not accepted at the U.E. and F.E.U. where I also applied, just in case.

I was ready to give up and maybe just become a medical representative, but my Mom was not. How she managed to do it, I don't know. But on the opening of classes last June, 1982, I was among 76 nervous freshmen at this medical college that I will be graduated from in a few months.

All told, by the time my parents waved me good-bye to start their trip back home that June, they had also parted ways with ₱32,000 of their hard-earned money — ₱9,000 for the first semester's tuition, ₱15,000 for the "donation" to the school "foundation", ₱5,000 for "non-compulsory" board and lodging for five months, ₱1,500 for medical syllabi and other materials, ₱500 for uniforms and ₱1,000 for two months' allowance.

They called it an investment. And for the past four years, I figure that Mom and Dad have cheerfully “invested more than ₱50,000 yearly towards the making of their doctor. If their investments have caused any financial difficulties, my parents have been careful not to worry me about them . . .

. . . When I was in second year, our professor in Pharmacology would come from Manila every Saturday (when there was no typhoon) to give us a whole week’s worth of lectures on the actions and administration of drugs. We would sit from nine in the morning to five in the afternoon. By the time the lectures were done, so were we — teacher and pupils all. We were glassy-eyed, achy-backed and ready to scream. I remember how our teacher looked, but not much more.

If Medicine can be learned by just reading books, it would not really have made much difference whether our flying lecturers came or not or whether laboratory work in Biochemistry was just a demonstration or a real hands-on experience. But as early as first or second year, we already knew that there are nuances, in the use of drugs for example, and key aspects in the understanding of how the human body functions that are not imparted by books. So, we missed being able to ask questions from knowledgeable teachers at the time when the questions were most impelling, and we missed making mistakes in the experimental lab (where it was safe to make mistakes) about the interpretation of biochemical reactions and the like.

Third year was suppose to mark our immersion into the clinical world. This was the moment we all waited for — when we would finally get to take a history and do a physical examination and be initiated into making and defending a diagnosis and suggesting a course of management for a real patient. At the regional hospital where we were supposed to do our clinical work, however, the x-ray machine which broke down two months before we came is still out of order and the lab can only do malarial smears and urinalyses.

Fortunately, our professor in Medicine was an astute physician who was used to making a diagnosis without too much help from the X-ray or Laboratory departments. He taught us that the ear can detect certain sounds from which to make the diagnosis of pneumonia and that one did not need a blood test to be able to tell that a man with yellow skin and eyes and tea-colored urine had jaundice. Still, it would have been nice if once in a while we could have seen the confirmatory shadow on the chest x-ray of a man with pneumonia.

I have no doubts about graduating this school year and going to internship. But I look to the medical board exams with much trepidation. So far, our school's batting average has been nothing to speak of. Last year, 48 out of our 62 graduates flunked and the others barely squeaked through . . .

. . . If there is one thing that I learned through these years, it is I do love Medicine. I feel good taking care of people and doing what I can for them gives me real satisfaction. I only wish I know more and could do more. My best times are spent in the children's ward and the kind of doctor that I'm going to best love being is a pediatrician, just like old Doc.

But where should I go to become one? There must be hundreds of us with the same ambition, but I am told that there are only so many residency positions in Pediatrics available in our training hospitals. So, it looks like I may not become a pediatrician after all.

Not that I mind becoming a general practitioner very much. One of the most caring doctors I know is a GP from a nearby town. But where would I set up my practice? Manila is my hometown and it is full of GPs already. I should set up practice in Marinduque. I hear there are few doctors there. Mom will probably have an apoplexy, but even she can be assuaged if she knew that I will be happy and safe there.

But what is happiness? For me, a large part of it will undoubtedly be in taking good care of people. But how good is the care that I can take of a patient for whom a needed drug is financially or geographically out of reach and for whom the nearest hospital is a half-day's dusty and bumpy ride away?

Can I expect even the slightest amount of professional growth and satisfaction under these conditions or will I ironically find consolation in the inadequacy of the medical education that I received? Would it ease my conscience somewhat to know that it does not really matter that I learned so little in school because there would have been no way to apply it?

And what about the more personal aspects of human happiness? If I married and were to have children, would I at least be able to give them a life of the smallest comfort? Would I be able to provide my children with a choice, to be a poet or a politician, and yes, even to be a doctor too?

My oath will dictate that I treat a patient without regard for creed, financial status or ideological persuasion. Can I feel

safe doing this or will I always have to bear Bobby dela Paz and Aurora Parong in mind?

My dear Dr. Cabral, where do I and all others like me go from here?

A medical student

—Where indeed?

And where do nearly 60 million Filipinos who will rely on this unfortunate medical student and his classmates go from here? From bad to worse, it seems. And not through any fault of either the people themselves or those who would become their doctors.

The letter-writer's predicament is hardly unique. The country's schools — believe it or not — are turning out more doctors, dentists, nurses and other health professionals than can be gainfully employed in this country. We have a glut. But at the same time, there is a chronic shortage of health professionals in the provinces. Almost two hundred towns don't have physicians. A bigger number don't have dentists.

How did we arrive at this sad state of affairs?

At the Asia-Pacific Conference on Medical Education last December 1982, the major problems of medical education in the Philippines were stated as:

1. The cost of medical education has increased tremendously and is now beyond the reach of most Filipinos. Yet, the income of medical schools are not enough to maintain a high standard of education.

2. There are not enough qualified faculty members in the basic sciences. Young graduates are reluctant to go into teaching in the basic sciences while older faculty are retiring or shifting to private practice. The situation is aggravated by the opening of so many schools so quickly.

3. There is a lack of good residency training positions in the country. In addition, medical schools and training hospitals are producing physicians who can man the secondary facilities. But there is little expansion and improvement of these facilities which are supposed to absorb the doctors we are producing.

These are the perceived flaws from the point of view of the students and their professors. The public has its own perception of the problems of medical education. For them, the bottom line is that more than half of all Filipinos are born and die without any type of medical care. And this is in a country that until lately had the dubious distinction of being the second leading exporter of doctors in the world and the number one exporter of nurses.

Historical Background: How More Became Less

The first medical college in the country, the University of Sto. Tomas Faculty of Medicine and Surgery, was founded in 1871. Thirty-six years later, the University of the Philippines College of Medicine was established. At the end of the Second World War, these two medical schools (that were then following the American system of medical education) were producing about 200 to 300 physicians yearly — obviously, nowhere near the needs of the burgeoning post-war population.

So, five more medical schools were set up; Southwestern University in 1946; Manila Central University, 1947; Far Eastern University in 1952; University of the East, 1956; and Cebu Institute of Medicine in 1957. By the late 1950s, these seven medical schools were turning out more than 1,000 doctors yearly.

It was hoped then that the increased output by the seven schools would ease the shortage of health manpower and help upgrade the nation's health status. Meantime, however, the population grew at an even faster rate. In addition, liberal and attractive conditions for medical training and practice in the United States resulted in the exodus of Filipino physicians that came to be known as the "brain drain." By 1975, nearly 38,000 physicians had been licensed to practice in the Philippines, 27,000 of whom were estimated to be active. Of these, at least 13,000 or almost half were out of the country.

The physicians in the country were lopsidedly distributed: about 70% of them practice in urban areas and only 30% practice in rural or semi-urban areas where 70% of our people live.

So, at the start of the last quarter of the century, the Philippines was in much the same predicament as 50 years back: there were not enough doctors and they were not accessible to a large part of the population. Worse, given the rapid advances in medical knowledge, the standards of health care in the country had fallen far behind.

At that time, the solution seemed obvious enough: open more schools — particularly outside Metro Manila — and produce more doctors. From 1975 to 1981, 13 new medical schools were authorized to open and three others began to operate under the license of other institutions. By 1984, there were 28 medical schools operating in the country. And in fact more doctors were produced. Between 1902 and 1950, the average number of physicians being licensed each year was 250. Between 1950 and 1980, an average of 1,300 were being licensed annually. From 1980 onwards, roughly 3,600 physicians are expected to be licensed yearly.



Producing more health professionals — the solution?

In a sense, the idea of producing more doctors worked. As Dr. Fernando S. Sanchez noted in a recent speech, the country now has a surplus of doctors. But the oversupply does not seem to be helping much to ease the shortage of current physicians where people need them. That is because the current glut appears to have been caused by the sudden closure in the last five to seven years of the job market for doctors in the U.S. The “excess” supply of doctors have yet to find their way out of the relatively well-serviced urban areas partly because facilities in the outer areas that would require their services are not being expanded.

Other Health Professionals

The status of other health professionals have also been going downhill over the past years. But their specific problems assumed different forms.

Nurses, for example, enjoyed until recently the option of finding work abroad. Nursing was seen as a passport to the U.S. and that prospect attracted thousands of young women to the profession. This provided a booming business for nursing schools which grew from 17 at the postwar period to 30 by 1960, 88 by 1974 and 130 by 1980. The number of licensed nurses reached a peak of 14,112 in 1978 (compared to the 8,508 nurses who were licensed during the entire decade of 1951 to 1960).

But when the U.S. started tightening up on the entry of foreign nurses in the late 1970s, many nurses found themselves out of work or

in low-paying jobs. Since 1980, enrollment in nursing schools declined. The schools have responded by loosening their admission policies which in turn led to a further decline in the quality of nursing education.

According to Sanchez, the dentistry profession has been less affected by the lure of overseas jobs. By his count, less than 15% of the total number of dentists have left the country. Eight dental schools were set up in response to increased demand due to population increase. Many of these schools borrowed money to set up their facilities. These schools are now hard pressed to pay off these obligations due to the economic crunch in recent years.

Pharmacy, on the other hand, has been slipping since the 1950s. "First, it became very expensive to put up a drug store. Then it became less profitable. Finally pharmacists are no longer needed in drugstores, only sales girls," Sanchez commented.

At the start of the 80s, only 14 schools in the country were offering pharmacy courses. From 1977 to 1981, the average number of pharmacists passing the board exams was slightly under 500 yearly.

The most numerous of health professionals, of course, remain the midwives. In 1980, there were some 50,000 of them according to records of the Professional Regulation Commission. Some 80 schools turn out over 4,000 trained midwives annually, double the number in 1970.

All told, however, the problems of education for health professionals are most acute in the case of physicians. One factor is the skyrocketing costs of medical education, far outstripping the other sectors.

Money and Medical Education

Medical education is expensive. A student today will spend anywhere from a quarter to half a million pesos during his or her four years in medical school and internship. And costs are escalating at about 30% yearly.

Private medical schools get their operational funds from tuition fees. Only two of our medical schools are state-supported. Fees per student per year range from P12,000 to P20,000 in private medical schools. Students in state-owned schools pay between P2,500 to P3,500 per year. However, student fees in government schools are in the process of being increased and this will eventually bring fees paid at the state-owned U.P. College of Medicine to about half of that of students in private medical colleges.

One also has to remember that medical education in state schools is heavily subsidized by taxpayer's money. It is estimated that the

government puts in ₱3 for every ₱1 that a student at the U.P. College of Medicine pays as tuition fee. Data from the Association of Philippine Medical Colleges (APMC) show that more than 50% of income from student fees is spent on salaries and other operating costs. Development needs have to be met by funding from other sources.

Since state support for private medical education is negligible and philanthropy for education is minimal, medical schools augment their incomes from much criticized individual "donations" by students, "development deposits" from incoming freshmen that may be returned when the student graduates or drops out.

This explains why competition to get into the U.P. College of Medicine is fierce. Even then, there were thousands of applications for slots in other medical schools despite criticisms that the quality of medical education given there seems to be inversely proportional to the amount of money charged.

The extremely high cost of medical education has led to a process of selection that practically delivers the health care system to an elite group of physicians who have collectively spent millions getting a license to practice and are now in a position to make their investment pay off.

According to current figures, more than 90% of all medical students come from families in the upper socio-economic bracket. About 50% come from Metro Manila, 25% come from Central and Southern Luzon, and the rest of the country account for the remaining 25%.

Thus, the typical profile of a medical student is that of a person from an affluent urban family, from Metro Manila or the surrounding regions. He or she would have to be very intelligent to have gotten into the better medical schools, or, he or she was prepared to displace somebody else with better intellectual qualifications but less money for the remaining slots in the more expensive but unproven medical institutions.

That kind of background is not likely to produce the kind of physician that the country is in dire need of, i.e., a service-oriented individual who will deliver health care where and to whom it is needed.

The Slipping Standards of Medical Education

Even as we recognize that the cost of medical education is now beyond the reach of most Filipinos, we are also faced with the fact that the income of medical schools do not seem enough to maintain the high standard of medical education required. One only has to visit some of the medical schools, including U.P.'s, to see how inadequate their facilities are.



Anatomy, for example, is traditionally learned through cadaver dissection. The ideal ratio of student to cadaver is one to one. In U.P., the ratio is four, which is still adequate. In many of the newer schools, it is 16. The library is one of the greatest sources of learning for the medical student. It is not an exaggeration to say that there is no single medical school with a good library to speak of.

The big rush in setting up medical schools in the mid 1970s put a severe strain on the limited medical faculty particularly in the basic sciences. The lack of qualified basic science teachers was recognized as early as the 1950s when there were only seven medical schools. Today, the problem is even worse. So is the lack of teaching hospitals and clinical materials. These are problems that are not readily amenable to financial solutions and will have to be dealt with in more time-consuming and effort-intensive ways.

If the passing rate in the medical board exam were to be taken as a gauge of the quality of medical education, then the trend over the years are dismaying. In 1970-1979, the average passing rate at the board exam was 81%. In 1985, the passing rate was only 50%. What happens to those who fail?

Appalled by this apparent waste of medical manpower, some members of the defunct Batasang Pambansa filed bills that would allow those who failed the board exams to be given a license in exchange for a period of rural service. One parliamentary bill — No. 1441 — sought to make five years of satisfactory rural service rendered by graduates of medical schools equivalent to passing the board examination.

Proponents of such measures argue that these would relieve the wastage of medical manpower that results from the rising casualty rates of the board exams. But on the other hand, what kind of medical manpower would the government be foisting on the community? Would this really solve the maldistribution of medical service delivery?

As was noted earlier, with the export market shut off, the country is gradually building up a "surplus" of doctors in such urban centers as Metro Manila, Cebu, Davao City and Baguio. The physician to population ratio in these places is a comfortable 1:1000. Elsewhere, however, physicians and other health professionals are scarce resources. The majority of our people live and die without ever seeing even a mid-wife or a nurse.

It is not really that the country does not have enough doctors to go around. It's more that they tend to stay where a livelihood can be earned, education for their children can be obtained and acceptable quality of life can be enjoyed.

Which is where most Filipinos are not.



Maldistribution of health professionals aggravates problems of accessibility to health care.

4

Highlighting the Lack of Care for Health Workers

by Prof. Minda Luz M. Quesada

Health workers constitute the labor force which provides a basic social service to its citizenry so that the latter could contribute productively to national growth and social development. This role becomes even more pronounced under the new government of President Corazon C. Aquino who has spelled out a social policy that would put a stress on the provision of adequate social services like health and education to majority of our people.

Health workers' participation in national reconstruction efforts, however, will require that their own very basic human needs of food, clothing, shelter, be addressed. It would be difficult to rely solely on exhortations for them to sacrifice some more and show more devotion to their work when they who provide care are not cared for. It is unkind and unfair of anyone to demand from the overworked and underpaid health workers selflessness in the midst of their own deprivations and suffering.

What then are these pressing work-life issues and concerns that have continually plagued health workers in various health care settings (hospitals, factories, schools, communities and clinics)? Would the new government of President Aquino be more responsive to their demands which the past regime only gave token attention to?

'Starvation' wages and salaries

As health care providers, health workers are expected to be good role models of health. They need to be healthy to have the energy, strength and resistance to carry on long hours of work and not to get sick themselves. Especially after being exposed to communicable diseases and other hazardous deleterious conditions. But with starvation wages, how can an ordinary health worker attain a minimum level of health and well-being? Consider the following:

- A staff nurse in a government health institution receives a basic salary of ₱1,068.75 (after the 25% salary hike implementation), COLA of ₱350 per month and a subsistence pay of



Compensation for health workers — are they commensurate to the weight of the responsibilities they carry?

₱180 or a gross monthly income of ₱1,598.75. With a total deduction of about ₱400 (GSIS, Medicare, Pag-ibig, Withholding Tax), her take-home pay will only be about ₱1,120. The nurse counterpart working in the private sector receives just about the same amount based on the daily wage (effective minimum wage) of ₱57.08 which computed for 22 days will amount to ₱1,254.

- Other categories of health workers definitely receive much less. A government hospital attendant only receives a measly ₱835 a month gross income. It is not surprising that they are forced to seek extra jobs to the detriment of their efficiency and effectiveness in delivering health care.
- Or an institutional worker with a monthly salary of ₱666 who has to support a family of six, pay for their education, spend for transportation and food while on duty, and obtain most essential goods for their sustenance. Even with a COLA of ₱350 a month and subsistence pay of ₱180, how far can this total income go?
- In mid-1984, the poverty line was already estimated at ₱2,502.98 a month and the estimated daily cost of living for a family of 6 in Metro Manila was ₱105.38.

(See Table 9 for a comparative listing of salary scales and benefits of other paramedical workers in the Ministry of Health.)

The problem of low pay is coupled with the grossly inadequate fringe and other benefits granted health workers. We refer to the P350 monthly cost-of-living allowance (COLA), P6/day, hospitalization benefits, hazard pay, night shift differentials, and clothing allowance.

While there are existing directives to provide some of these benefits, their implementation is always subject to "availability of funds". For example, majority of the hospital workers of communicable disease hospitals who are entitled to hazard pay (being constantly exposed to infectious agents of disease) have not enjoyed this benefit. What is even more demoralizing is the fact that when they get sick of communicable disease they are confined in the charity wards instead of the infirmary for employees. They also have to pay for all medicines.

Understaffing/overloading of health staff

These affect the quality of health care because the standards of health care cannot be effectively implemented. For example, in some big government hospitals, the ratio of nurse to patient is as high as 1:120. This problem is ironic when there is a big supply of nurses produced each year by the 142 colleges of nursing, averaging from 10-11,000.

In the study of Agagan in 1980, she estimated the minimum demand for staff nurses in Metro Manila government and private hospitals is about 30,215 but only 11,238 are actually employed. Some hospitals have actually resorted to the use of "volunteer nurses" who serve as a source of cheap nursing manpower. These newly graduated nurses are able to acquire a certification of hospital nursing experience required for overseas employment.

Some hospitals make up for the problem of understaffing by using health students in providing needed health care. This practice, however, is exploitative and resorted to as a means of cutting down on health manpower costs; the practice should also be discouraged because this affects the quality of the education and training of the health students as well as patient care.

One consequence of understaffing is the practice of making health workers go on overtime work without pay. In some instances, health workers like nurses and nursing attendants are obliged to go on extended duty, as long as sixteen duty hours.

Insecurity of tenure

Many workers — such as institutional employees whose services are essential to the delivery of health care — are still employed as casuals even after satisfactory services of more than 5 years.

In private institutions, health workers feel the threat of losing their jobs for the flimsiest of reasons, but most often when the workers are becoming assertive and actually start organizing efforts in their institutions.

The current source of insecurity among government workers is the directive for all health officials down to the division chief levels to tender their courtesy resignation. While these do not apply to the rank-and-file, somehow this governmental action has put a cloud on whether career or civil service rules will be observed in the process of effecting organizational changes.

Lack of genuine democratic rights

This refers to health workers' right to organize or to join associations of their own choice, freedom of peaceful assembly within the premises of the hospital or agency, the right to collective negotiations concerning their work-life conditions and the right to speedy and due process of resolving legitimate grievances.

The Marcos dictatorship repressed these fundamental rights of workers. Even now, there are vestiges of the 'dictatorial' attitudes and behavior of management in both government and private institutions. It is not uncommon to observe the repressed behavior and attitude of rank-and-file workers even after the February people-power revolution which should have set them free.

During the Martial Law years, graft and corruption was perpetuated, even legitimized, because of the absence of effective fiscalization and social controls which health workers' organizations could provide if only they were free to assert such controls.

Quick turn-over of health personnel

Health facilities (hospitals, rural health units and medical centers) are constantly plagued with the problem of resignations of highly trained and skilled health manpower. This has affected the quality of health services and burdened these facilities with the high cost of staff training and development.

The health sector is known to be a contributor to the phenomenon of brain-drain or reverse transfer of technology. This may be explained by the following factors:

1. Poor working conditions and the desire of health professionals to seek greener pastures.
2. Unemployment or the lack of appropriate job opportunities in the country.
3. The desire of health professionals to upgrade their technical



Photo: World Health Organization

The worst child killers can be prevented through immunization.

skills or to apply their western oriented knowhow.

4. The encouragement of government policy-makers to health professionals to seek overseas employment as this would bring in much-needed foreign exchange earnings to pay foreign debts.

Overseas employment however, has created other social problems which counterbalances its desired benefits, namely, it: a) deprives the country of much-needed trained health manpower, b) wastes the social investments in these important human capital, c) deprives the country of potential tax returns, d) creates social problems among families, e.g. broken families, mental health disorders, etc., e) reflects government's in-ability to transform human resources into productive forces for national development and f) satisfies needs of developed countries to have cheap labor in their own health care system and health/industrial establishments.

Inadequate facilities and supplies

These conditions so prevalent in government health institutions compound the rest of these work-life conditions since these frustrate, impede the help-giving and caring ideals among our health workers when they are powerless or helpless to prolong life, heal the sick or prevent unnecessary deaths.



What the prerequisites for professional advancement?

For example, health workers complain of frustration when they have to tell patients or their families to buy much-needed medicines or supplies before any emergency intervention could be made. As a result of implementing this hospital policy in government hospitals, health workers have to bear the brunt of the public's anger for their seeming indifference or callousness. This situation has unconsciously transformed the once-caring health workers into alienated beings who try to submerge their concern as a defense mechanism against their powerlessness to remedy the situation.

Lack of opportunities for professional growth

Many health workers complain that there are not enough programs within their institutions that would encourage them to develop their potentials. Also, they often experience dehumanizing treatment from superiors such as when they are scolded in front of patients, their families or co-workers, berated like they were small children, and subjected to other abusive acts as if they had no feelings.

They also deplore the fact that management and supervisors seldom give praise for good things done but are quick to notice inadequacies or misdemeanors.

There may be many more of these issues and concerns but these situations are the most frequently cited ones, either individually or collectively in small and big group forums/dialogues and discussions.

The Pitfalls of Mixing Profit and Public Health

by Gemma Nemenzo-Almendral

Linda, 25 years old, tries vainly to hold back her tears as she retells the short, tragic life of her youngest daughter, who died at the age of three of measles and bronchopneumonia.

The girl had been coughing badly for weeks but the mother, used to seeing children afflicted with colds, thought it was just a reaction to the erratic February weather. Then came the high fever; that alarmed Linda. But because she and her husband did not have money, it took two more days of rashes and convulsions before they could bring the child to a doctor. After having a nurse inject the girl with an antibiotic, the doctor prescribed three different medicines.

At the drug store, the mother discovered that the money she had was not enough for the prescribed drugs. So, she bought a few tablets of aspirin instead. That evening, the child grew sicker. The parents panicked and rushed the child to the nearest hospital, where she was taken in as a charity patient.

The little girl hung on for three days. "Binibigyan siya ng gamot, pero madalas nauubusan ng stock. Kaya kailangang bilhin sa labas. Sari-saring tableta (They were giving her medicine, but their stock often ran out. So we had to buy outside. There were many brands; none of them cost less than a peso per tablet)," Linda says.

For a jobless carpenter like Linda's husband, the cost of the medicines meant begging his neighbors for loans. "Minsan napapautang ako ng P2, minsan P5. Walang-wala rin naman ang mga kapitbahay namin kaya't hindi rin namin nabili ang lahat ng sinabi ng doktor (Sometimes we could borrow P2, sometimes P5. Our neighbors are broke, too, so we couldn't buy everything the doctor prescribed," Asiong, Linda's husband, explains.

On the third day, the little girl died. Linda was not with her because she was out earning money by washing clothes for a fami-

ly. The hospital people said the girl's illness was too far advanced and the erratic intake of medicine did not help.

Linda and Asiong could not help but blame themselves. If only they were able to get enough money to buy all the medicines their daughter needed, they mutter over and over again.

Linda and Asiong's story is not an isolated case. The tragic tale is replayed in countless variations in the slum areas of cities, far-flung barrios in the countryside and in government hospitals that cater to the poor.

Such stories highlight the importance of drugs to effective health care, and, also how inaccessible modern medicines are to too many Filipinos. Such a deplorable situation is obviously due to widespread poverty. But matters are worsened by the way the drug industry in the Philippines is set up and run.

In the recent years, drug companies, particularly the multinational corporations (MNCs), have repeatedly come under fire from critics who charge that their overriding drive for profit-making has blocked reforms aimed at making essential drugs more accessible to the poor.

The Drug Industry: A Consistent Money-Maker

There are about 280 pharmaceutical companies operating in the country. They make about 2,500 kinds of drugs, sold under roughly 8,000 brand names.

Drug manufacturers routinely complain about the small size of the domestic market, meaning that too few people can afford to buy their products. But this hasn't kept them from becoming consistent money-makers.

In 1984, for example, the 50 largest drug firms hiked their combined sales by roughly 30% — from P3.3 billion in 1983 to P4.25 billion. This despite the domestic economic slump due to the debt crisis, the consequent 15% cutback on the importation of raw materials and 12%-16% drop in sales volume.¹

Drug firms, particularly the MNC's, have traditionally registered high rates of return on investments (ROI). According to *Business Day's* Top 1000 Corporation, the 34 largest drug firms posted a return on investment ratio of .22 for 1983 and 1984. That means that these companies are getting P22 of net income out of every P100 of net equity, a respectable performance that the industry has managed to retain for years.²



Businessmen, Not Bishops

The predominance of private firms in the drug industry is something that is taken for granted. In fact, drug manufacturing and distribution are in the hands of private businesses in most countries, except for the socialist bloc. The operations of these companies are geared towards satisfying the market demand, i.e. their products are for those who can pay for them. As an Indian doctor observed regarding the situation in his country: "The drug industry, like any other, produces only to the extent that drugs can be sold at a reasonable profit in the market, irrespective of the needs of the people."³

There seems nothing wrong about the logic. The only problem is most of the people in the Third World countries, those who need medicine the most, are too poor to afford them.

In her book *Bitter Pills*, Diane Melrose put it this way: "Scientists and managers within the (drug) industry are acutely aware that poor people are deprived of vital drugs. Poverty is the main constraint and drug producers are in no position to end poverty. The pharmaceutical industry acknowledges however, that it has special obligations arising from its involvement in public health. In practice, actual marketing policies are inevitably determined by the demands of running a viable and profitable commercial operation. Companies have workers to pay and shareholders that want a return on their investment."⁴

The same author quotes a spokesman for the British drug industry which operates worldwide: "You must understand that the reason multinational companies try to grab back as much profit as possible out of the less developed countries is frankly because they are suspicious of the future stability of their operations there. I would just be talking rubbish if I were to say that the multinational companies were operating in the less developed countries primarily for the welfare of these countries . . . They are not bishops, they are businessmen."

In the Philippines, the industry's critics say officials of drug companies have not only been sharp businessmen but also tough power players who use their collective clout to frustrate attempts at reform that may jeopardize their profit-making. To weigh the merit of that accusation, however, requires taking a look at some important characteristics of the local drug industry.

Who Controls the Industry?

One striking fact about the Philippine drug industry is the domination of foreign multinationals. The figure showing the extent of the foreign control vary and can be confusing. According to the Drug Association of the Philippines (DAP), only 50% of the industry is in the hands of foreign firms.⁵ The DAP, which has a membership of 89 drug manufacturers, is itself dominated by MNC subsidiaries. The Chamber of Filipino Drug Manufacturers and Distributors, on the other hand, says up to 75% of the industry is foreign controlled.⁶

A *Business Day* news item, apparently referring to data from the International Medical Statistics Phil. Inc., reported that of the roughly 270 pharmaceutical companies covered by an IMS survey, 22% are American-owned, 35% are European, 33% are Filipino while Asian and Middle Eastern companies make up the remaining 10%. Foreign ownership thus adds up to about 67% of the total.⁷

Another *Business Day* report said however that there are only 52 MNCs operating in the country.⁸ Part of the confusion may stem from the varying equity structures of various drug firms, particularly those that are joint ventures between foreign companies and local investors.

In any event, even a smaller number of MNCs does not change the reality of foreign domination of the drug industry. Of the top 30 firms covered by an IMS survey done in January-February 1985, 28 are MNC subsidiaries; collectively, their sales accounted for almost 60% of total industry sales.⁹

Carving Up the Drug Market Pie

MNC subsidiaries in the country try to downplay the extent of the foreign domination of the drug industry by stressing that an all-Filipino firm, United Laboratories Inc., has the largest single cut of the local drug market: an average of a little over one-fifth of the total. Some officials of these foreign firms privately complain over how Unilab is favored by the government saying that the company is run by persons close to Malacañang.

The more relevant observation that can be made based on the available data is that Unilab and the top 28 MNCs make up the industry cartel. Their combined sales account for roughly 80% of the total; the balance of 20% is shared by about 240 companies.

After Unilab, the top sellers of pharmaceutical products were MNC subsidiaries. These include such well-known names as Bristol Meyers, Warner Lambert Phil., Abbott Laboratories, Pfizer, Squibb, Glaxo, Smith Kline and French, Johnson & Johnson, Schering, Hoeschst, Sandoz, Eli Lilly, Bayer and AHS Phil.¹⁰

It's also worth pointing out that while Unilab does manufacture its own product line, it also produces drugs under license from such foreign firms as the United American, Westmont, Beecham, Imperial Chemical Industries, Shering and G.D. Searle. So, it should not come as much surprise that, according to the *Far Eastern Economic Review*, the share of foreign companies in the Philippine retail drug market is the highest in Southeast Asia.¹¹

The High Rate of Import Dependence

One of the most serious criticisms levelled against the drug industry is that it hardly does any real manufacturing to speak of. What the industry passes off for manufacturing is merely an importing, compounding and packaging operation.

About 95% of the raw materials for medicines are imported. This high rate of import dependence costs the country about \$120 million to \$150 million yearly and makes the drug industry vulnerable to shortages in foreign exchange or peso devaluations.¹²

A case in point is the import squeeze in late 1983 and 1984 due to the country's debt crisis. To avert possible shortages, the government had to give drug imports high priority. When the first installment of the standby credit facility extended by the International Monetary Fund was released in 1985, the biggest single chunk — some \$15 million — was allotted for drug imports.

Such difficulties were foreseen back in the 1970s. But the drug industry has failed to shift from nearly pure importing to basic production. Why?

Drug industry sources say the cost of setting up basic production plants, which would need sophisticated research and development facilities, is exorbitant and cannot be sustained by the local market.

Esteban B. Bautista of the University of the Philippines Law Center says otherwise:¹³ "If (their reason) is true, then why are they setting up plants that manufacture basic drug materials in Indonesia? . . . There is no patent law to protect their products (there) unlike here in the Philippines. They are also committed in Indonesia to produce within five years one basic drug material from local resources."

The UP professor argues that "it is hardly surprising that the foreign enterprises engaged in the industry have no desire to push it beyond the importing-compounding-and-packaging stage of development because even at this level, huge profits are raked in. Apart from the fact that Philippine labor is cheap for the most labor-intensive aspects of the industry (compounding and packaging), importation enables them to manipulate costs and prices to their utmost advantage."

He cites the case of Ampicillin, a popular antibiotic covered by a Philippine patent. In 1976, Beecham (one of the licensees) imported from its mother company 362 kilos of Ampicillin at \$251 per kilo. A month earlier, Unilab (a contractual licensee of Beecham) imported from the same source 2,000 kilos of the same material at \$141 per kilo. At around the same time, Doctors Pharmaceuticals, a local drug outfit, bought Ampicillin from an Italian supplier at the world market price of \$91 per kilo.

"Beecham claims that their Ampicillin is of higher quality than what Doctors is importing from Italy. But of course, they cannot fool us because we know that they are also importing Ampicillin from Italy," Bautista says.

This practice of a MNC subsidiary buying raw materials from its mother company at an inflated price is popularly known as "transfer pricing." It is a standard operating procedure of MNCs, not only in the drug industry. "The higher the price fixed, the better for both subsidiary and mother company (since they are really one) for they can justify a higher distribution price for the product or bigger deductible expenditure for tax purposes. More likely than not, royalty payments have also been built into the import price to save the mother company from the automatic transfer of profit or payment of royalty to the home office," Bautista says.



Why are drug prices so high?

The High Price of R & D?

MNCs justify the generally higher prices of most of their products (as compared to those of Filipino firms) by saying each one is backed up by an extensive — and costly — research and development process aimed at ensuring quality and efficacy. Indeed, the development of drugs like antibiotics — which have saved millions of lives in the past few decades — would not have been possible without hefty spending in R&D.

A United Nations study published back in 1971, for example, explained that it takes 175,000 chemical entities to extract 1,300 compounds that can be tested in clinics. For every 8,000 substances tested only one will be useful. So, the price of the useful drug will have to include a part of the cost of developing and testing 7,999 failures. What's more, a US drug industry report says companies have to spend \$11 million and work seven years to develop a drug up to the point of bringing it into the market.¹⁶

Most R&D is done in the developed countries. In 1984, for example, the major US drug makers spent more than \$4 billion on R&D, double their expenditures in 1980.¹⁷ Major drug MNCs reportedly spend more than 10% of revenues for R&D. As a result, many new drugs enter the market every year. In the US, for example, 90% of the drugs are less than 20 years old.

Industry critics, however, don't view the issue of R&D costs kindly. UP's Bautista, for example, stresses that many of the new drug introduced yearly are not really innovations but reformulations of drugs that have been patented. This make possible the introduction of more new brands, but not necessarily of genuinely new drugs.

Because of these reformulations, the rate of drug obsolescence is high (in 1977, the annual average was 4.5%) and this sets off a vicious cycle wherein the manufacturers have to continuously pass on R&D costs to consumers in order to recover the expense of coming up with new brands.

Significant innovations in drugs — in contrast to brand development — have been relatively few and far between. Melrose quotes figures from the US Food and Drug Administration that reveal that "only a minority of new products licensed offer any major therapeutic advance. Out of a total of 484 new drug applications approved over a five-year period, 112 were new chemical entities, 106 new formulations and combinations and 252 replicas of existing formulations. According to the FDA, of these, 31 represented an important therapeutic gain, 62 a modest gain and 391 a minimal or non-existent gain."¹⁸

British licensing authorities reached a similar conclusion in their own study of new drugs. They found that innovation is directed

towards commercial returns rather than therapeutic needs.¹⁹

In the Philippines, where not much R&D goes on as far as foreign drug firms are concerned, industry critics have questioned the practice of passing on R&D costs to consumers, specially if sales in the home country have already recovered the cost of R&D.

The issue of R&D costs as it relates to Third World consumers is tackled extensively by Melrose: "Most new drugs are not directly relevant to the needs of the Third World poor, but are for conditions which are common, largely chronic and occur principally in the affluent Western societies."²⁰

He cites two sources:

* "In 1976, the World Health Organization (WHO) estimated that total world expenditures on R&D for tropical diseases amounted to L17 million a year — a sum equivalent to two percent of the money spent each year on cancer research alone;"

* An industry analyst discovered that "out of a total R&D expenditure of around \$5,000 million in 1980, the international pharmaceutical industry spent over \$50 million on specifically 'Third World drug research.' In other words, in 1980, the international industry allocated just one percent of research and development spending to poor world diseases — or about half as much as it costs to develop just one new drug."

One counterargument to this criticism is that even the poor benefit from sophisticated researches on, say, heart disease, cancer and other illnesses which affect people of both rich and poor nations. Furthermore, any breakthrough in immunology techniques may also be helpful in treating other tropical diseases.

There is however "a wide gap between theoretical benefits and concrete advantages to the poor. The poor of Third World countries are still not benefitting from essential drug technology developed in the 1950s and 1960s," Melrose says "Since they are expected to contribute to the cost of this research (by paying higher prices for brandnames drugs) it is essential to question how far the research actually sets out to benefit people in developing countries."

The High Costs of Brand Names

According to Dr. Nelia Maramba of the UP Philippine General Hospital (PGH), there were some 15,000 brand names flooding the local market (The number has since been cut down to about 8,000). These represent some 3,000 generics or basic drugs. The list, she argues, can be cut down to 600 generics. The recommendation of the UP PGH drug committee is even stiffer: cut the list down to 270 essential drugs, excluding laboratory chemicals and reagents.²¹

The idea here is that the country's essential requirements for medicines can be met by about two percent of the total number of brand names. Therefore, importation should be limited to these essential drugs.

So, why so many brand names? Answer: For many drug firms, particularly the MNCs, that's where the money is.

Many drug multinationals aren't interested in generics because price competition in that market is stiff, profits are lower and companies will be hard put establishing clear strategic advantages that promote longterm growth for the firm. Instead, they opt for searching for growth areas by developing new products and brands through a heavy R&D effort.

Generics producers in contrast don't have to shoulder R&D costs because their products are those with expired patents and so can be manufactured by any other company. They manufacture in large volumes and sell at bulk prices.

Research-based drug firms rarely compete with the generics makers at the low-price market segment. Instead, they make their money by turning out new products that can sell at high prices while they are protected by patents. Each company tries to hike its market share in about half a dozen different sub-markets. Glaxo for example specializes in antibiotics and drugs for asthma, rheumatism, ulcers, skin ailments and heart conditions.

An official of Ciba-Geigy, as quoted in *Bitter Pills* explained the strategy of research-based MNCs this way: "The innovator is compelled to develop new innovations if he is not to fall behind in the competitive race. Theoretically, the research-based company could defend its market share, even after expiry of the patent, by effecting price reductions. Such a strategy, however, involves the danger of its tying down a growing proportion of its resources as a company to this generics market and thus weakening its capacity for research and development."²²

Drug Prices and Marketing Hoopla

While drug MNCs make much of their R&D spending, the real big-ticket item in terms of expenditures is marketing.

One study of the United Nations Commission for Trade and Development (UNCTAD) found that major international drug companies spend three to four times more on marketing efforts than for R&D. Marketing expenses account for as much as one-third of the value of sales.²³

Promotion is done through different forms and channels. In the Philippines, huge sums are spent in media advertising for drugs for

common ailments, such as colds and coughs, which can be bought at most retail outlets, including *sari-sari* stores.

Even more costly to the consumer is the practice of patronizing doctors. To do the job, drug firms hire a battalion of sales representatives known in industry parlance as detailmen. Their primary task is to sweet-talk their way into the confidence of medical practitioners. That way, detailmen can keep doctors updated on the names and claimed efficacy of the company's latest products so that physicians elect to prescribe these drugs rather than those of competing firms.

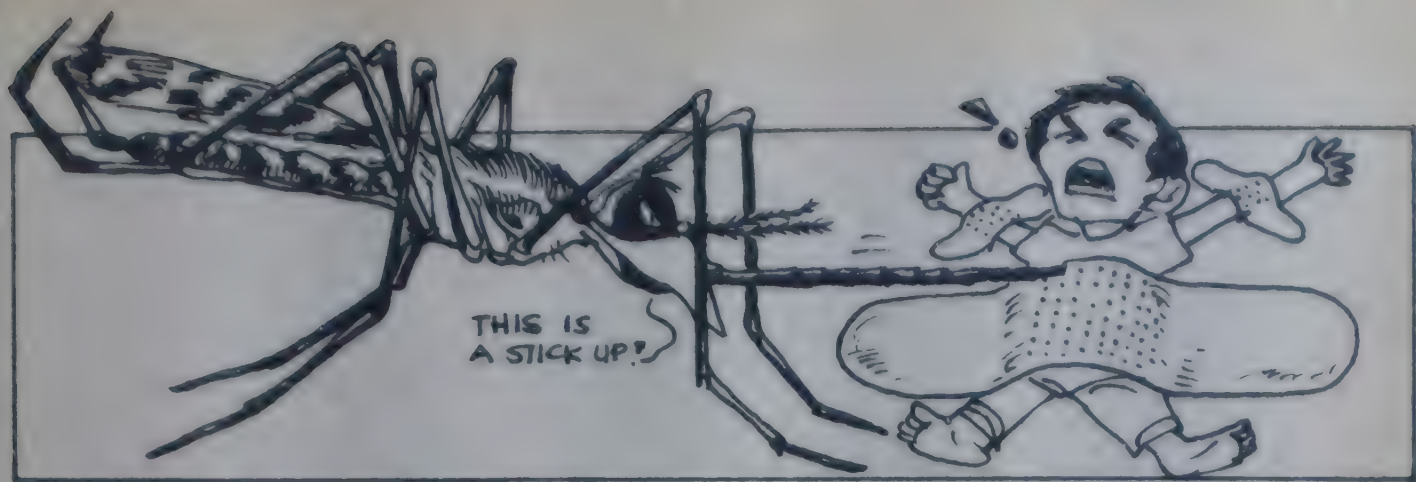
Since competition is tough, marketing tactics can be as indelicate as brass knuckles; they include the dubious practice of giving targeted doctors all sorts of gifts (in cash, kind or grants). Industry critics, specially those in the medical profession, say such promotional gimmicks not only foster a mendicant attitude among doctors, but may also result in wrong or inappropriate and unnecessarily expensive prescriptions.

If You Can't Convince Them, Confuse Them

The training given detailmen lends weight to such accusations. The process was described by Dr. A. Dale Console, a former medical director of E.R. Squibb and Sons in the US, who later became a leading industry critic:²⁴

"From one of them, I learned the simple maxim, 'If you can't convince them (the doctors), confuse them.' . . . In teaching and instructing detailmen one must attempt to inspire them over a product that is, more often than not, uninspiring in order to increase sales volume to its maximum point . . . The primary purpose of the detailman is to make a sale even if it involves irrational prescribing and irrational combinations that contain a prophylactic ingredient furnishing an ideal path to confusion . . ."

Another highly effective tactic is to underwrite the projects of medical associations. Regarding this, Dr. Eduardo R. de la Cruz, author of the book *History of Philippine Medicine and the PMA*, proudly acknowledges the role of the local drug industry in supporting activities of the Philippine Medical Association. The aid came in various forms: sponsorship of conventions and meetings, post-graduate study grants, financial support of community services and research, conduct of management seminars and the like. De la Cruz says that "it is through these activities that the pharmaceutical firms were able to promote their products effectively to the physicians, in addition to retailing activities of their respective drug representatives."²⁵



Why More Is Spent for Band-Aid Than Anti-Malarial Drugs

The heavy stress on promotions by drug firms has been tagged by industry analysts as mainly responsible for the distorted drug spending priorities of consumers, specially in developing countries like the Philippines.

"Developing countries need large quantities of a small number of essential drugs, above all those that can prevent and treat disease," says Melrose. A cursory list would include among others anti-tuberculosis drugs, anti-malarials, antibiotics and a few key pain-killers. But as two senior pharmacologists describe the situation: "Unfortunately, a good proportion of the drugs available are of little importance in terms of essential health care and they are marketed mainly because they can be sold and not because they benefit the health of the population."²⁶

The World Health Organization (WHO) is more caustic: "In recent years, many medicinal products have been marketed with little concern for the differing health needs and priorities of different countries. Promotion activities of the drug manufacturers have created a demand greater than the actual needs."²⁷

The Philippines is a good example. Medical practitioners have pointed out that almost half of all drugs sold in the market are for symptomatic therapy, which means that while the medicine relieves the symptoms it cannot cure the disease.

In 1980, Dr. Vicente Escobar, a pharmacist specializing in herbal medicine, reported that among others:²⁸

- * Filipinos spent over two-and-a-half times more money on cough and cold medicine (P287 million) than on anti-TB drugs — even though none of the cold drugs can really cure the common cold and though tuberculosis has been a leading cause of deaths for decades;

- * About P28.9 million was spent on pimple and acne preparations; this is *seven times* more than the value of anti-malarial drugs sold — even though malaria is endemic in rural areas and its incidence is rising anew;

* Some P6.6 million went to anti-obesity preparations and another P4.7 million for cholesterol reducers; the combined amount of P11.3 million is 52 times the sum spent on medicine for leprosy victims which numbered then about 20,000.

The relationship between these lopsided spending habits by consumers and drug firms promotional thrusts are fairly clear. A good number of the top selling products (cold preparations, vitamins, antacids and pimple preparations) are those heavily advertised in media. These commercials have apparently reinforced the well-off's propensity for "sophisticated" formulations to cure even the most minor maladies.

Industry spokesmen have argued that the poor also consume the fast selling drugs. Consumer groups argue though that the consumption of unnecessary drugs by the upper classes have a "demonstration effect" that misleads the poor.

Doctors have also encouraged even impoverished patients to buy multivitamin tonics and other non-essential products. Often, these patients, in their desire for immediate relief and the prevention of recurrence, spend their scarce pesos for such products, instead of buying the right kinds of foods that would make them unnecessary.

Banned Drugs, Anyone?

In the early 1980s, there was a big hullaballo about chloramphenicol. The use of this drug had been restricted in the West for its side effects, but it was being sold over-the-counter in many drug stores in the country.

Its local manufacturers justified the continued distribution of chloramphenicol by saying that local medical researches have not established whether Filipino users suffer from the same side effects as consumers in the West. So, until then, the drug will still be sold freely. Chloramphenicol was eventually reclassified as a prescription drug.

Later on, Mead Johnson became the target of the criticisms for trying to bring into the country infant formula that had exceeded their expiry dates. Public pressure eventually forced the American MNC to junk the idea. The company made it a point to announce that the shipment was rejected. The whole episode could not however assuage the discomfiture of mothers who have started to wonder if other such shipments manage to slip into the country unnoticed.

The practice of selling products rendered unmarketable in the West by strong consumer pressure is called "dumping". News items on banned drugs in 1984 indicate that the Ministry of Health has been issuing announcements on the banning of certain drugs. These include tetracycline (which was banned as a drug for children below eight

years old), neomycin (which was banned in anti-diarrheals as of 1982) and dihydrostreptomycin (which was totally withdrawn since 1972). There were reports however that some of these drugs which were banned as far back as 1972 were still available in some outlets up to 1984.²⁹ This fuels consumers' suspicions that, as in the case of infant formula, other harmful substances are being marketed unchecked.

The Battle Over Essential Drugs

In line with its goal to achieve 'Health for All' by the year 2000, the World Health Organization proposed that international action be taken to promote the use of essential drugs and curb some of the questionable practices of drug companies. The framework and directions for this effort were set during the 31st World Health Assembly in 1978, which adopted the Action Programme on Essential Drugs or the Drug Action Program (DAP).

WHO director-general Halfdan Mahler explained the programme's rationale: "Essential drugs, which can cope with the overwhelming majority of the problems even in relatively sophisticated societies, number around 200. But for the villagers and urban slumdweller, great miracles can be achieved with fewer than 30 well-chosen drugs."³⁰

WHO came up with an essential drugs list (EDL) and recommended that governments take measures like centralized bulk purchasing of these drugs, the promotion of generics rather than brand names and cheaper standardized packaging. However, because actual policies and implementations were left to individual governments to work out, WHO's plan for a vigorous, coordinated international campaign for a new health order ran into snags, the biggest of which is the still opposition of the international drug industry.

The industry started lobbying against the DAP at the 1978 Assembly itself where its representatives distributed a position paper entitled "Medicine and the Developing World." The paper raised two major arguments against the action programme. First is the assertion that the Code is a "means of transferring income and assets from the private international firms of the West to the Third World nations of the South and East" through "nearly confiscatory price controls." The second argument attacks the essential drugs policy as a "state-dictated reallocation of wealth."

It has also been argued that the concept of an essential drugs list is basically unsound because people of different races react differently to each drug and that it fosters the growth of monopolies. Industry critics counter however that the WHO Code merely asks for reasonable drug prices and that even with the basic drugs list the drug

market remains very much in the control of the American and European MNCs.

On the soft-sell side, the drug industry has taken pains to project its "voluntary" adoption of WHO measures like marketing codes that check its most criticized practices — like direct selling by detailmen of infant formula and potentially dangerous drugs to consumers. The industry has also come up with its own EDLs.

In both cases, however, consumers' groups have accused the drug companies of trying to blunt efforts at reform by proposing watered-down versions of the WHO code that don't really curb questionable practices.

In the Philippines, for example, the code for marketing infant milk submitted by the industry to the MOH differed greatly from what pro-breastfeeding organizations had drafted in line with WHO recommendations. The industry list of essential drugs ran up to 1,700 as against the 600 listed by the MOH committee and the 300 of the UP PGH committee.³¹

Who's In Charge: Regulators or the Regulated?

Considering how vital medicines are to the public welfare, governments are expected to be vigilant in regulating the drug industry. That does not seem to be the case in the Philippines. Many rules and regulations either remain ambiguous or are considerably structured to allow drug MNCs to go about their business essentially as they please. Regulatory authorities are either unwilling or incapable of firmly implementing standing rules that adversely affect industry interest.

For example, the Philippines is one of the very few countries in the world that issues patents for the pharmaceutical product itself *and* the process for manufacturing it. What's onerous is the government gave away this concession — which reinforces the already formidable advantages of the giant firms that have funds and facilities to continuously develop new brands — without getting in return a clear commitment from drug companies to support the development of local capabilities to produce needed pharmaceuticals.

In contrast, Indonesia — which does not grant patent protection to drug products — requires companies operating there to produce within a specified period drug material using local resources.

The MNC lobby has in fact succeeded in stonewalling or watering down policies that aim to protect local manufacturers and consumers. One demonstration of the lobby's influence was the emasculation of a 1976 presidential decree drafted by the UP Law Center that originally sought to impose stiffer regulations on the operation of MNCs.

particularly in such matters as patents and licenses.

During the public hearings, representatives of the local subsidiaries of drug MNCs were among the most vocal in opposing the proposed decree. When the measure was signed into law, they continued to press for its revision, if not repeal. This intense lobbying effort got support from the US, West German, Swiss and Japanese governments; their embassies in Manila expressed concern over the decree's "adverse effects" on foreign investments.

A few months later, the decree was amended to appease these foreign interests. Eventually, significant provisions such as those on voluntary licensing, which was the cause of much of the agitation of the drug companies, were removed.

Favoring the Foreign Over the Filipinos

Government intervention — or inaction — has not uniformly benefitted the industry as a whole. MNCs tend to be favored at the expense of small — and medium-sized Filipino outfits.

One such case is an obscure policy regarding drug distribution. This concerns the ban imposed by the government on licensing new drug distributors unless they sell only products of foreign firms. The government also prohibited the registration of new brand names of locally-made medicines.

This policy was instituted back in the mid-1960s but remained largely unenforced. In 1983, however, the government strictly implemented it, provoking a strong reaction from local drug manufacturers. The Chamber of Filipino Drug Manufacturers and Distributors attacked the policy for favoring only MNC brands and causing the unnecessary rise of drug prices by undercutting competition from distributors of local brands. The chamber added that the policy also encouraged the production of unregistered drugs, which may be of dubious quality.

One local manufacturer said: "If you want to be a drug distributor, you have to assure the (Food and Drug Administration) that you will only sell the products of multinational companies and you are sure to get a license. However, just say you are going to market locally produced items and your application gets an outright disapproval."³²

The government lifted the ban in March 1985 due to stiff opposition from local manufacturers. But it appears that the damage has already been done. One news report in February 1985 quoted industry sources saying that about half the number of marketing firms that exclusively distribute locally made brands had already closed down. This was caused partly by the generally poor business conditions. Another major reason was the decision of Filipino-owned drug companies to cut

down their production of local drugs after the FDA's regulations had "decimated" the ranks of their marketing outlets.³³

Essential Drugs: Too "Hot" to Handle?

In the face of MNC opposition, the health ministry has been unable to make substantial progress in implementing the WHO's recommendations for instituting an essential drugs policy.

Actually, an excellent opportunity to put such a policy into effect cropped up during the early months of the country's debt crisis, when the acute shortage of foreign exchange for imports compelled government to attempt setting some kind of priorities in the importation of drugs.

The drug association strongly opposed the idea, saying they would be amenable to a 20% cutback in their usual dollar allocations so long as the government did not draw up a permanent list of essential drugs.

"The (essential drugs) list infringes on free enterprise," said Katipunan M. de los Reyes, general manager of Sandoz Phil. and then drug association president. He said limiting drug imports based on an EDL would undermine competition and lead to higher prices. A better explanation for the ferocity of the drug association's opposition was the observation made by the head of the Makati Medical Center that some companies have no product at all in the preliminary list prepared by the MOH and would be forced to close shop if the ministry limited drug imports to that list of essential drugs.³⁴

In any event, despite its obvious reluctance (Health Minister Azurin was then quoted as being against the idea of having the EDL), the health ministry went on and finalized a list of some 440 generics culled from the 1,700 brands proposed by the drug association. The basis for this selection remains unclear because Health Minister Jesus Azurin announced that he was reluctant to release the list, saying it "may create a full-blown controversy . . . (it) is a delicate thing to phase out or delist drugs from the market because each drug reportedly takes millions of dollars and years of testing to develop . . ." ³⁵ Meantime, reporters covering the MOH were denied access to any information on the drugs list and all matters pertaining to drugs.³⁶

In any event, upon learning of the completion of the MOH EDL, the drug association denounced it as " . . . interfering with the professional judgement of doctors and ignores the number of deadly though not prevalent diseases . . . (it is) like 'playing god' by deciding who should receive treatment and who should die." ³⁷

Dr. Vicente J.A. Rosales, then president of the Philippine Medical Association, backed the stand of the drug companies and argued against the imposition of any restrictions on the imports of drugs as

part of a generics drugs policy. The PMS president said an EDL is "open to misinterpretation that all pharmaceutical products can be done away with."³⁸

The opposition to the EDL appears to have succeeded because nothing has been heard of the MOH "finalized" list since.

That is hardly surprising because the government, MOH in particular, has consistently shown great reluctance to adopt decisive policies regarding the drug industry.

Some years back, for example, the health ministry created an advisory group, the Technical Assistance of the Food and Drug Administration (TAFDA), to study policy issues related to drugs. In 1983, the group was abolished, its work unfinished, for "undefined reasons." It was reported though that the TAFDA, which was headed by Dr. Maramba (UP pharmacology professor), had written a memorandum to Minister Azurin, recommending the withdrawal from the market of 30 drugs that had been found to have doubtful efficacy, quality and safety. Curiously, Azurin denied having received the TAFDA memo.³⁹

In a sort of backdoor response to the public clamor to make the EDL public, the MOH Bureau of Food and Drugs released lists of banned drugs and of drugs the registration of which were renewed. Meantime, moves to establish a clear drug policy on the basis of the WHO's advocacy of generic drugs for the majority of the population remain stalled.

Looking back, the medical associations must share some of the responsibility for blocking the progress of a real generic drugs policy. Aside from the PMS, the Association of Medical Directors of the Philippine Pharmaceutical Industry (AMDPPI) also opposed efforts to promote the use of generics. AMDPPI officials said that shifting from the brand drugs to generics has been "ineffective" in both developed and developing countries."⁴⁰

These associations tend to view a generics policy as an infringement of the physician's prerogative in prescribing the most modern or appropriate drug.

The larger question though is how such prerogatives can be reconciled with the social realities in the Philippines. According to Dr. Quintin Kintanar, deputy general of the National Science and Technology Authority, at least 75% of the country's sick population are not reached today by modern drugs.⁴¹ The apparent reason, among others, is poverty on so large a scale that modern medicine has virtually been made irrelevant to the bulk of the population.

Prices and Crises

The matter of generics resurfaced in mid-1985 this time in relation

to growing public complaints about the spiralling costs of drugs.

The drug manufacturers maintained that the price increases were unavoidable because their raw materials — 95% of which are imported — had been bought at a time when foreign exchange was scarce and expensive due to the country's debt crisis. The companies also had to deal with high interest rates.

In a session of the media forum *Kapihan sa Maynila* in July, 1985, Minda Luz Quesada of the Alliance of Health Workers pressed the government to adopt a generics drugs policy as a means to check rising drug prices.

Minister Azurin however ruled out government moves to impose price control on pharmaceutical products, arguing that this may simply result in drug shortages. Shortly after, however, the MOH, as if acknowledging the validity of criticisms against the industry's pricing policies, got the drug firms to go along with minor "voluntary" price cuts for a few products.

Despite this, the situation remains basically unchanged. Drug prices remained subject to volatile economic conditions, while the government remains unable to take bold initiatives that offer some hope of moderating price shocks and helping the country develop the means to make the drugs that the majority of the people really need.

Is There a Poverty of Options?

Going by the MNCs' logic, there are no viable options other than the present set-up wherein private firms selling brand-name drugs dominates the market and service people's needs — so long as public needs manage to conform with their quest for profit.

But the Philippines does have choices, going by the recent experiences of some countries that have dared to change the ground rules of pharmaceutical manufacturing in ways that make it more responsive to people's needs.

Nations like Bangladesh, Tanzania and Sri Lanka have started stressing the use of generics rather than brandnames and have taken steps to better protect the interests of their citizens. These efforts have not been easy, as resistance from drug companies remain strong.

For example, one report has it that an imaginative drug firm in Tanzania was able to persuade the government to buy a bulk supply of an antibiotic enough to last 46 years based on estimated requirements — even though the product's shelf life is only six months.

Still, there are success stories. One such case is that of a small African nation, Mozambique.⁴² Formerly a Portuguese colony, the country's drug market was dominated by multinationals. Drugs were readily available to the nation's white population in the urban

centers, prescribed by white doctors. Whatever medical services were made available to the black population could be had only in the cities and, as a South African journalist reported, they were merely an attempt to "provide a *cordon sanitaire* around the white suburbs than for any humanitarian consideration."⁴³

When the country gained its independence in 1975, after a prolonged guerilla war led by the Front for the Liberation of Mozambique (FRELIMO), the health care system was turned inside out to serve also the rural population.

The new government's stress on reforming the health care system had far-reaching effects on the drug industry. The health ministry set up a pharmaceuticals commission to study the country's drug requirements and to identify the most urgently needed medicines. Those with the fewest side effects and the lowest cost were chosen.

In 1980, the commission issued an EDL of only 343 generic drugs. To cut down costs further, the government set up a state import company, Medimoc, which then published each year the list of drugs it planned to import. Drug firms were then asked to submit their bids. This practice fostered real competition between pharmaceutical suppliers and led to substantial cost savings.

These benefits were passed on to consumers nationwide through government health centers that price medicine depending on Medimoc's bulk import price and the income of the patient.

To ensure that the reforms took root, massive education campaigns on proper drug usage were conducted. Medical practitioners attended seminars on drug prescription and consumers were taught the benefits of, for example, inexpensive oral hydration formulas to control diarrhea.

The net result of these changes: more widely available health care services and a drug import bill that has been kept from ballooning even though more pharmaceutical products have been made available to the people.

There are other examples of alternative drug policies such as those of the socialist countries (like China and the Soviet Union) that have built their health care systems on a socialized basis and have been recognized as being successful in meeting people's health needs when compared with the previous set-ups in those countries.

A few examples of course do not clinch an argument. The attempts of various Third World nations to break away from the conventional wisdom of the international drug industry and establish a new health order are of fairly recent vintage. These alternatives will have to stand the test of time.

Still, it must be embarrassingly instructive for the Philippines that a country like Bangladesh, which is even smaller and more poverty-

stricken, has demonstrated greater imagination and spunk in dealing with the dilemmas of drug policy.

Zafrullah Chowdhury, the architect of Bangladesh's new drug policy which stresses generics, was the 1985 Ramon Magsaysay Foundation awardee for community leadership. During a visit to Manila, Chowdhury noted that the prices of drugs in the Philippines are as much as 300% higher than equivalent drugs in Bangladesh, which is trying to produce more and more of its pharmaceutical requirements.

Though he observed that various factors — such as taxes, labor and other manufacturing costs — contribute to the higher prices of medicines in the Philippines, Chowdhury stressed the role of the multinationals. He said the MNCs do not really compete with each other in price terms and can thus control prices.

"I am not against multinationals, but I am against cheating people. It's better that they leave you. Don't take for granted that they will follow the rules," he said.

Multinationals need Bangladesh more than Bangladesh needs them. The same goes for the Philippines, he stressed.⁴⁴



Are multinational companies providing us with the drugs we need?

Towards an Alternative Health Care System

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The Aquino government's rise to power has fired up hopes that real changes for the better can now be realized — including the establishment of a health care system that is more effective, humane and equitable.

The obstacles blocking basic changes in the health sector, however, are formidable and deeply-entrenched. This point deserves emphasis, not to pour cold water on earnest reform efforts, but to highlight the need for determined and sustained efforts at thorough-going change.

The Need for Systematic Change

Attempts to reform the health care system has to be system-wide and deep-going because the sheer magnitude of the problems and their inter-connectedness point to no other conclusion. Piece-meal solutions will at best produce piece-meal results. At worst, these could backfire and exacerbate the situation.

The health system is embedded in the larger social system. Inequities in health care closely reflect larger social, economic and political inequalities. The way mass poverty keeps butting into and complicating proposals for health care reform is a nagging reminder that there's no getting around the need for a systematic approach to change. While most medical professionals tend to gloss over this fact, it remains that a modern, effective health care system cannot be built on a foundation of medieval poverty.

This means lasting reforms in the health sector cannot be accomplished apart from similarly sweeping changes in the social and economic situation.

The Broad Agenda

All this, however, does not devalue the importance of reform initiatives within the health sector itself. Shortly after the February 1986 uprising, task forces in and out of the health ministry started to develop alternative reform strategies.

Rather than mapping out detailed blueprints for a new health care system, it may be more fruitful at this point to identify the *basic directions* that the process of change will have to take and the *hard policy choices* that have to be confronted.

Such a broad agenda will have to include the following:

- * Big doses of additional funds — particularly public monies — have to be pumped into the health sector;

- * The health care system has to be restructured and rationalized to focus on meeting the needs of rural and urban poor communities at the primary level;

- * A clear set of policies on medical technologies — particularly drugs — has to be formulated and aggressively implemented, with emphasis on appropriate technologies that are low-cost and that meet the needs at the primary level; and

- * Health care has to be “de-medicalized” and the health professions reoriented with a view to developing relevant skills and competencies and, perhaps most importantly, stronger professional commitment to public service.



Spending: A Matter of Priorities

The strain on government resources has hardly eased following the downfall of the Marcos regime. It has in fact gotten worse. Still, the new government has to find ways of committing a larger share of public funds to social services, including health.

This is essentially a political question. The government suffers from a severe cash shortage that has grounded many plans for improvement in the social service sectors. Precisely because this problem is likely to persist, government has to set its priorities clearly. This means the national leadership has to make hard and — in some cases — politically explosive decisions to shift its spending priorities away from wasteful and counter-productive activities such as costly infrastructure “impact” projects and an oversized military.

For the public health sector, fresh infusions of funds are in order immediately. New money is needed just to keep the state health system from sliding further down the pit. The dismal state of many government hospitals underscores the need for quick action in this regard.

How much more money is enough? Rather than batting for unrealistically large increases of the government's health budget, the more practical and justifiable target would be to bring the Philippines up to par with *other developing countries*. The government's health budget is only about half of one percent of the country's gross national product (GNP). Many developing countries spend from two to four percent of their GNP.

How would setting a spending target for health of about two percent of GNP translate into pesos? With a GNP of ₱607 billion (in current prices) in 1985, government should be spending some ₱12.1 billion directly for health care concerns. The health ministry's budget for 1986 is ₱3.4 billion.

Shortly after his appointment, Health Minister Alfredo Bengzon asked for a budget of roughly ₱10 billion. As large as that sum sounds compared to what the health ministry used to get, that figure is slightly below the *lower range* of what other developing countries are even spending for health as a proportion of their GNP.

A big jump in public spending for health now will simply make up for years of declining investments under the Marcos regime. The public sector's share out of total health spending went down over the years — from about 45% in the early 1970s to 37% in the latter part of the decade.

Not surprisingly, the state-run health care system — from the primary to the tertiary level — ran into severe financial problems. This took place at precisely the time when the economic crisis put private health care beyond the reach of an increasing number of people. Scattered reports from hospital administrators indicate for example that hospital admissions have dropped to below 50% of capacity because patients cannot afford the costs.

Such people tend to turn to government facilities. This trend is placing heavier burdens on a public health care system that is already being stretched to the breaking point. Many will be turned away and many will stop going even to government facilities. The count of those dying without any medical attention will probably rise beyond the already appalling rate of 60%.

As a distinct discipline, health care economics remains largely undeveloped and big strides must be made in this field to answer the challenge of building an effective yet viable health care system.

Bigger public spending must be complemented by better mobiliza-



Health care financing: an imperative.

tion of private funds. Hospitalization and other health benefit programs of the Social Security System and the Government Service Insurance System should be reexamined with a view to maximizing the benefits from these resources.

Present Medicare benefits are grossly inadequate and have to be upgraded. At the start, Medicare used to pay up to 70% of hospitalization expenses. Now, it covers only 5% of costs for “serious” cases and 15% to 20% of costs for “ordinary” cases. One proposal calls for creating a distinct fund for Medicare, as opposed to the present set-up where the program piggybacks on the SSS and GSIS.

SSS and GSIS funds may also be tapped for financing the expansion of health facilities — such as provincial hospitals — preferably for the public sector. This will require careful study because these financial institutions cannot commit such funds without regard for the financial viability of such projects. But there should be greater leeway for such ventures, especially now when these institutions should be freer from political pressures that led to the placement of funds for ventures that benefitted only a small group.

Side by side such efforts, private sector initiatives to mobilize private savings for health care should be encouraged. Examples are company health care plans and health maintenance organizations or HMOs. In exchange for the payment of monthly fees, HMOs

guarantee their members subsidized if not free hospitalization should they fall ill during the year.

The HMO concept suffers from serious limitations. They help only those who have enough incomes with which to pay the monthly premiums. As matters stand, Filipinos in general are able to allocate too little — less than two percent according to the National Census and Statistics Office — of their incomes to medical care. But HMOs can still play a positive role. Done on a sufficiently large scale, HMOs can help lower significantly the costs of hospital care for its members and at the same time mobilize private savings to directly sustain health care service facilities.

Restructuring Health Care Priorities

Pumping more money into an inherently maldistributive system, however, only worsens the misallocation problem. In the case of our health care system where the emphasis lies in urban, curative and hospital-based services, a change in emphasis to rural, preventive and community-based services will not come about simply because more money is spent.

Apart perhaps from emergency fund infusions, government has to restructure its health priorities before large sums poured into the health care system will make a real difference.

What does restructuring health priorities mean? One way of looking at this is to view the current shape of resource allocation as an inverted triangle, where the tertiary sector at the top receives a disproportionately large share of the funds and very little money finds its way to the bottom — the primary care level.

Restructuring would mean adding funds to the bottom. Since funds are limited, this will mean cutting down at the top.

This process of reallocation is both a political and budgetary exercise. In the past, while a lot of lip service was paid to the importance of primary health care, funds for it were allocated only after the budget needs of the health ministry's facilities were first met. In effect, primary health care programs got the leftovers. If there were no funds, PHC got nothing. It's easy to understand how and why that happens. But restructuring health priorities now must mean that PHC programs are allocated funds on a firm basis and that other sectors of the health care system have to adjust accordingly.

This will require that government take a good look at tertiary level institutions and decide which of these have to be trimmed down. A case in point would be the Lung Center. One proposal is to make the Center function as it should — *a center for training and research*. This would require defining the Center's *core program* to properly reflect

this role. With this done, it would be possible to segregate those activities which are tied up with its function as a research and training center from those which are not. This would then make it possible to convert part of the Lung Center into a *general tertiary hospital* earning its own keep and acting as a *national referral center*.

The other side of this adjustment process requires deciding more critically on which primary- and secondary-level health programmes to pursue. It is not enough to decide for example that the operations of one health facility ought to be reduced or halted because of inefficiency or duplication. We must go further on to defining the alternative projects or activities on which the now untied resources can be spent on. In this way, the health sector can better evaluate through cost-benefit or cost-effectiveness studies the rationality of policy and project choices.

This review and reevaluation should be guided by the following principles:

- * As far as the delivery of health services is concerned, the stress should be on increasing the people's access to the system. This would mean, among others, placing emphasis on preventive programs and on primary and secondary health service;

- * The relationship between health and development should be explicitly recognized;

- * Genuine community participation in the planning and implementation of health programs must be encouraged;

- * On the part of government, this will entail decentralization of both operational and budget management.

Pushing Primary Health Care

The key requisite for making the PHC approach work is community participation, not just in implementation but also in planning. This is possible only where community-based organizations genuinely supported by the people have taken root.

Since 1981, the health ministry under the Marcos regime was supposed to have been implementing the PHC approach nationwide. By 1985, MOH documents report that the PHC approach was officially being implemented in all except one percent of the country's roughly 40,000 barangays. MOH barangay health workers numbered 365,941, with a ratio of about one BHW per 20 households. It was claimed that a total of 14,718 *Botica sa Barangay* were established with an almost equivalent number of pharmacy aides trained to man these village pharmacies.

Upon taking over, however, Health Minister Bengzon discovered a disparity between the reported achievements in primary health care

and the real state of affairs. Critics moreover question whether there was any real community participation in much of the MOH's claims of open and thus have been better able to top grassroots initiative and implemented in a top-down fashion — as would be expected of a bureaucracy — with little time for reorienting ministry personnel and winning support and cooperation from the supposed participants at the grass-roots level.

More important, however, it is open to debate whether the ministry was able to come to grips with the PHC approach. Advocates of primary health care stress that PHC is often confused with building more rural clinics — i.e. improving the delivery of health care services. While that is certainly part of it, PHC encompasses much more. PHC is a framework, a way of approaching health care that emphasizes the direct and sustained participation of the people in improving their health.

Understandably, non-governmental organizations (NGOs) have been relatively more successful in pursuing such a broad PHC approach. Unhampered by the fetters of bureaucracy and the ideological biases of the deposed authoritarian regime, NGOs have been more flexible and open and thus have been better able to tap grassroots initiative and cooperation. Community-based health programs are active in some 40 provinces with about 200 health personnel as staff and some 3,000 community health workers as volunteers.

While gearing up the health ministry's machinery for a real PHC thrust, it would be pragmatic for the government to encourage NGOs to pursue their respective programs. At the least, it must move away from attitudes of the past which placed under the shadow of suspicion community-oriented programs that aimed to develop a self-reliant and independent spirit among the grassroots.

NGOs however have their own soul-searching to do. Some NGOs still adhere to a sort of "charity" or dole-out orientation. The thrust should in the longrun be towards "community-managed" primary health care programs where local communities get beyond being mere recipients of assistance from agencies and start taking matters into their own hands.

Pushing Appropriate Technologies

As the World Health Organization stressed in its Alma-Ata 1978 Report on Primary Health Care, PHC requires the development and use of appropriate health technology that meets the most urgent needs of the people.

Appropriate health technology covers a lot of ground. One example is the effort to tap proven traditional medicinal practices. But the

most controversial and arguably most critical policy issue here is the matter of pharmaceuticals.

On this score, WHO recommends that governments set policies and regulations on the importation, local production and sale of drugs. These measures are intended to ensure that needed drugs are available at the least cost.

Under the Marcos regime, however, proposals to rationalize the country's drug policies in line with the PHC thrust got nowhere. The establishment of a new and hopefully more independent-minded administration has created a rare opportunity for innovative policy reforms regarding drugs. The most basic reforms include the following:

1. The government must adopt a national Essential Drugs List (EDL) as recommended by WHO.

This proposal hasn't gotten off the ground here largely due to stiff opposition — sometimes open, other times indirect — from the drug industry. The industry claims among others that the use of an EDL would deprive the public of other needed drugs that are excluded from the list.

However, an EDL makes much sense for a country like the Philippines which is burdened by a huge foreign debt and must use its scarce resources — particularly foreign exchange — as intelligently as possible. That's why when the country ran into foreign exchange problems due to the debt crisis in late 1983, the health ministry announced it was drawing up an EDL; drugs included in the list would be given priority for foreign exchange releases to drug firms importing such products or materials.

That EDL however died a quiet death. According to insiders, the MOH's original list of 170 items grew to 440. The industry was lobbying for 1,700 items to be included in the EDL. After a while, the proposal simply dropped out of sight.

The EDL is supposed to be a guide, to give due priority to drugs found to be most needed by a particular country. Based on an EDL, both government and private agencies can then decide what to do. The government for example can offer a subsidized pricing scheme for essential drugs. Tax cuts can also be granted on this basis.

2. The use of generic drugs should be encouraged. Conversely, the registration of new brand names and "me-too" drugs should be limited.

The advantages of promoting generics are obvious. Properly produced, generic drugs are cheaper and can meet much of the pharmaceutical needs at the primary level.

At the moment, only United Laboratories and Rhea Pharmaceuticals are producing generics. Other companies could follow

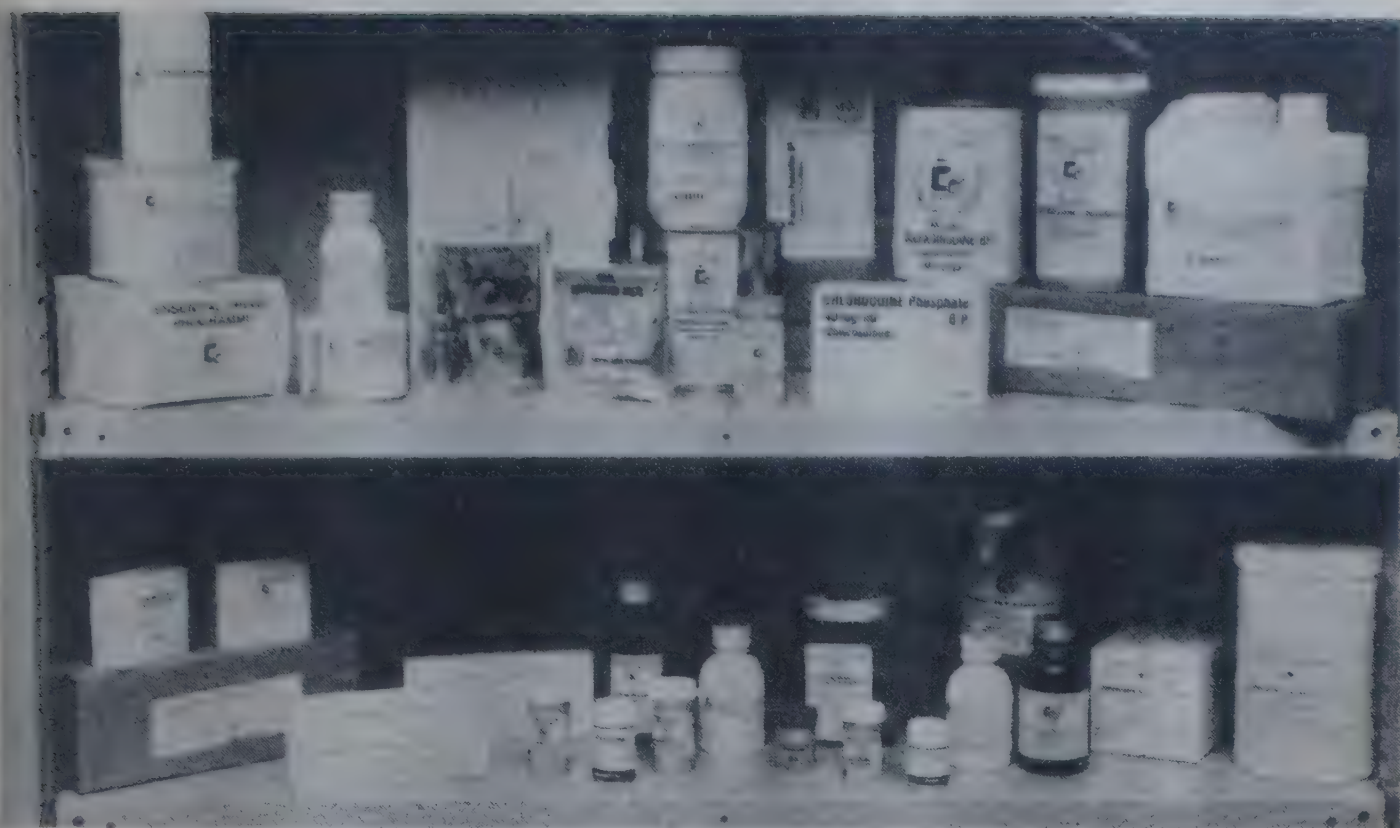


Photo: World Health Organization

Generics can lower drug prices substantially.

their lead. In the past, drug companies balked at doing so, claiming that there are differences in quality between different brands. One way to resolve this dispute is to subject the different brands to an independent test to determine if such differences exist and to what extent. Another compromise is to allow firms to tack a pre-fix before the generic name of a drug to indicate the manufacturing company, e.g. UL-Generics for Unilab products.

In any event, the government must as a matter of policy discourage the irrational proliferation of brand names and “me-too” drugs. This set-up creates confusion among health professionals and consumers alike. This also jacks up the cost of therapy when a doctor prescribes a more expensive brand name simply because that is the only one he has heard of, courtesy of the many drug representatives dispensing free samples.

3. Drug regulatory authorities have to be strengthened.

Off-hand, the country does not lack for laws and regulations regarding quality control and the distribution of pharmaceuticals. For example, back in 1970s, administrative orders were issued imposing strict controls on the registration of new brand names. The rules, which were almost tantamount to adopting to a generics policy, remain unenforced however.

A key stumbling block to serious enforcement of such regulations

was the feeble state of the two drug regulatory bodies — the Bureau of Food and Drugs and the Dangerous Drugs Board. Both bodies were strapped of cash and saddled with antiquated equipment. The BFD 1985 budget for example was a measly ₱5.8 million while the DDB had to make do with ₱13 million.

BFD is getting a new laboratory. But what it needs most perhaps is a hefty infusion of fresh verve and nerve as it has to contend with an influential lobby of well-heeled and well-connected drug firms that includes large multinationals.

4. An independent information network on drugs should be set up to provide the government, health professionals and the general public with accurate and reliable data on pharmaceuticals.

The lack of independent information on drugs is one of the most critical hidden problems that stand in the way of the rational use of drugs. Both public and private sectors need ready and regular access to accurate information on the efficacy and safety of drugs, including possible side-effects and precautions that need to be taken.

In other countries, consumer groups publish independent drug bulletins. There is no readily available counterpart in the country. The Philippines still does not have its own national formulary.

Independent information mechanisms make it possible for both the government and public to decide intelligently on the use of drugs — and to take extraordinary action in case of abuses. Such an information network would for example make it possible to implement the necessary regulations on the advertising and marketing practices of drug firms such as “truth in advertising” guidelines.

Self-reliance in Drug Needs

For reasons of both cost and self-sufficiency, the government has to gradually push for more real local manufacturing — as distinguished from the repacking that now passes off for manufacturing. Such a course of action does not necessarily mean adopting an isolationist policy and booting out the multinationals. It does mean though that government and Filipino business must demonstrate greater ingenuity and sophistication.

One innovation would be to set up a network — either state-owned or private — for procuring pharmaceutical products from abroad at *competitive prices* rather than through the cartelized systems of multinationals that are out to sweeten their profits through transfer pricing. The idea is to bring greater competition into the scene — a move that will hopefully result in lower prices and improved availability of needed drugs.

The country can also do well with a pharmaceutical manufacturing

firm — whether state-owned or private — that *will produce essential drugs at low cost*. The experience of Bangladesh has already shown that the technological and financial barriers to such an effort can be hurdled. Gonosthasaya Kendra set up the now famous pharmaceutical firm in that impoverished country with only \$4 million — a drop in the bucket when compared to the huge loans that the country has incurred for white-elephant projects over the past two decades.

Kendra's plant now produces the most essential drugs — including antibiotics — with good quality and at costs as low as one-fourth those of multinationals.

Such moves are certain to spark a debate not only about health policy but also about general investment policy. There are bound to be protests over "excessive government interference" and "unfair state competition." But it is also clear that the government has compelling reasons from the perspective of both health policy and investment policy to take such initiatives.

Defining Roles: Government and the Private Sector

Implicit in all these initiatives is the assumption that the government has to play a leading role in reforming the health care system. That idea isn't likely to be well-received in some quarters for a variety of reasons.

For one, people still vividly remember the bitter experience of over a decade of largescale intervention by an authoritarian regime. In the light of disclosures since his downfall, Marcos' grand development schemes filled the pockets of a few and left the rest deep in debt.

Others, particularly the business people, opt for free enterprise as a matter of faith. They look at government intervention — no matter how nobly motivated — as inherently flawed.

However the matter is discussed, debates over the role of government ultimately have ideological underpinnings. Liberal and socialist-minded people on the one hand normally urge more while free enterprise advocates bat for less government. The debate can become even sharper in an area such as health care, where private profit-making easily falls under the shadow of suspicion. At the same time, simple do-gooding is vulnerable to the charge of being charity schemes that are simply impractical.

This debate will ultimately be resolved not in the health sector but in the larger political arena.

In any event, the case for largescale government intervention in the promotion of primary health care has firm pragmatic moorings. The PHC approach is anchored on the realization that "health cannot be

attained by the health sector alone." It recognizes that enduring improvements in the people's health cannot be achieved without similar advances in nutrition, water supply, sanitation, housing, environmental protection and education.

Such improvements in the social infrastructure cannot be attained apart from general efforts to promote economic and social development. These are processes in which government must inevitably take the lead even if such initiatives will take the form of paring down its role in some areas.

Moreover, such things as safe water and sewerage systems, education and environmental protection are often considered as "social goods" wherein the State has a legitimate interest and a clear responsibility. Left to the vagaries of market forces, such vital social services are bound to be neglected, or their development will be skewed in favor of areas and social sectors where purchasing power will lead them. Government has thus little choice but to take the lead in these concerns. And by so doing, it will take a giant leap towards promoting primary health care.

In any case, existing conditions in the Philippines virtually guarantee that there will continue to be substantial roles for both the public and private sector — and perhaps even for a third variety: a cooperative sector.

That at least is implied by the primary health care thrust. One of the key elements of the PHC approach is local initiative and community participation. Aside from state-owned and privately-owned hospitals, cooperatively-run hospitals should eventually rise to take their place in a more equitable health care system.

The Health Professions: Reforming the Practice and the Practitioners

Reforms in the health care system cannot be sustained unless the process of change reaches into the health professions as well. The reason for that is, as one writer put it, "the dominant perspective on health feeds on the dominant perspective of medicine."

If primary health care is to be pushed aggressively, then certain aspects of the medical profession have to be changed.

One such aspect is the excessively "mechanical" or "technological" orientation of modern medicine. The other — and this is related to the first — is its emphasis on specialization and the resulting glorification of the specialists.

As it has developed, medical science has focused on bacteria, parasites, viruses and toxic substance as the causes of diseases. To cure one afflicted with illness means eradicating such harmful factors.

Victims of diseases are treated much like an engine being repaired by a mechanic. Illness is seen as a malfunctioning of the human machine and the process of curing the patient means fixing up his affected part.

Nothing wrong here — except that this view shuts out the social, economic and political dimensions of health. Health and illness are seen as individual issues. And even situations or problems that are social in origin are treated as purely “medical” cases.

Translated into health policy-making, the technological view of health has “provided the main justification for the increasing expenditures demanded by high-technology medicine, reinforcing a health care system in which hospitals play the central role and receive a disproportionate amount of resources to the detriment of simpler forms of less spectacular care,” argued Kadt. “Above all, it elevated the actions of the expert, the specialist to a central position in the achievement of health. . . In short, it *medicalized* health and continues to do so. . .”

This socially-blind orientation permeates the profession and is passed on unchallenged to succeeding generations of practitioners through the schools. One medical student was shown data showing the relationship between mass poverty and communicable disease. His reaction: “We never talk about these things in class. We’re too busy with lab subjects.”

The primary health care approach will however require turning some of these things around. For one thing, it requires “demedicalizing” health in the sense that relevant medical knowledge has to be redistributed — among the health professions and with the public.

As the laws stand, for example, nurses strictly speaking are not authorized to administer intravenous treatment. The situation is worse for PHC workers; it is illegal for them to administer any kind of injection. This monopoly of authorized medical knowledge conferred on physicians has to be broken. Paramedical personnel, given adequate training for specified purposes, must be given a greater role in administering various kinds of treatment at the primary level.

Knowledge has to be shared with the community as well through health education campaigns and health courses both in and out of school. Some refer to this process as “empowering” the people to enable them to take a decisive role in meeting their health problems. The importance of such campaigns has been demonstrated in countries such as China where massive health campaigns — such as the eradication of pests — helped achieve dramatic improvements in public health.

Reacting to the dominance by the specialists, some advocates of primary health care take a dim view of the role of doctors. In their eyes, doctors are just bit players in this drama and the real heroes are the village health workers who take on not only health care duties but also community organizing functions.

That is probably swinging to the opposite extreme. But there is little doubt that doctors — being at the top of the medical totem pole — will feel the greatest pressure for change. There will be increasing demands for public accountability and for a dismantling of the monopoly on authorized medical knowledge.

This is a pill that will probably be hard for some physicians to swallow. Doctors have traditionally been jealous of their professional prerogatives. In May 1983, for example, the Philippine Medical Association reacted sharply to a draft national code for the marketing of breastmilk substitutes proposed by the health ministry. The PMA argued that the draft code was “derogatory” to the medical profession because it implies that doctors can be “cajoled” by marketing gimmicks “into prescribing what is not good for their patients.”

Such a posture may not help the medical profession when complaints of excessive charges and other such malpractices continue to crop. Practitioners, it appears, face two choices: more stringent State regulation or tougher self-regulation. What will probably emerge in the long run is a blending of both.

Doctors and other health professionals do not of course have to wait for external pressure to bear down on them. It is a matter of patriotism and legitimate self-interest that they participate in the reform process.

One critical area is the field of medical and paramedical education. Curricula have to be recast so that society develops the right mix of skills appropriate to the dominant health needs of the population. Medical schools must emphasize not only competence but also relevance — and with that, a firmer commitment to public service.

Otherwise, training more doctors and nurses will not add up to better health care for our people, but merely longer queues of visa-applications at foreign embassies.

Ultimately, better health presupposes a better society. People — including health professionals — have to help create such a society through their efforts as better citizens.

Appendix

A Few Notes About Health Statistics

by Michael L. Tan

People generally have mixed feelings about statistics. There is, on the one hand, the feeling that statistics are products of academicians and computers. And yet, others feel more comfortable when figures are cited, almost as if the numbers carry some mystical power. It is not enough to say, "Many have tuberculosis"; instead, one has to say "Six out of every thousand Filipinos have tuberculosis".

Statistics are formidable tools, but one should recognize that they are never exact and that in many cases, statistics are used for manipulation and deception. On the positive side, statistics are meant to be guides for action, helping us to understand problems so that solutions can be formulated. If they at times seem forbidding, it is because they are vested with such qualities to obscure, to manipulate or to deceive people. To understand statistics is therefore vital in understanding even the causes of the problems reflected in those statistics.

We present here a selection of statistics to help us in understanding the health care system in the Philippines. But before wading through the figures, we should recognize that the figures come mainly from government agencies, since they are the only ones that can provide statistics on a national scale. As with any set of statistics, certain limitations should be recognized, particularly if comparisons and conclusions are to be attempted.

Coverage And Sampling

Different surveys will have differences in the scope and methods of sampling. Thus, we will cite figures from the Ministry of Health (MOH)'s Health Intelligence Service, which draws on reports from provincial offices for data such as morbidity (illnesses) and mortality (deaths), which are compiled and published as an annual called *Philippine Health Statistics*, the latest of which covers data for 1983.

The MOH also conducts *periodic national health surveys*, which samples a fixed number of households, from which *projections* are made for the nation as a whole. In the 1981 National Health Survey, for instance, 8,481 households were covered from 652 barangays. Based on the data from this sampling, projections are made for the na-

tional population, which has about 10 million households in 42,000 barangays.

It should not be surprising, then, that in the 1980 *Philippine Health Statistics*, the morbidity rate for tuberculosis is reported as 232.4 per 100,000 while in the 1981 *National Health Survey*, the rate is given as 1182.7 per 100,000 for tuberculosis as a *chronic* disease and as 121.6 for "those presently suffering" from the disease. Checking with the National Institute of Tuberculosis (NIT), another government agency under the health ministry, still another figure is given: based on a survey of 23,254 people, the "tuberculosis prevalence rate" based on smear-positive cases (microscopic examination of sputum to detect *infectious cases*) is 0.66%, which translates into a figure of 660 per 100,000.

The example shows that differences in sampling can be significant. Not only are we dealing with different population sizes, but we also find different criteria. The MOH Philippine Health Statistics would depend on cases diagnosed as tuberculosis and reported to the local government health office; the National Health Survey depends on cases reported by the household heads and the National Institute of Tuberculosis depends on positive cases in sputum examination. It would therefore be misleading to mix figures from the three different surveys, even if the numbers deal with the same diseases.

Baseline Data

Related to the point made above is the matter of baseline data. Statistics are best used when comparisons can be made across a certain time period to indicate trends such as progress (or lack of it) in the control of a certain disease. Again, the problem is that there may be changes in the methods used to collect the data, making it difficult to compare statistics even for a five year period.

An example not directly related to health is that of unemployment, which the Marcos government had been fond of boasting as one of the lowest in the world, fluctuating between 4% and 5%. But, as the University of the Philippines' School of Economics points out, starting in 1976, anyone who had worked for *one hour during the last three months* was classified as "employed". Before 1976, the criteria was having worked one hour during *the past week*. (UP School of Economics, *An Analysis of the Philippine Economic Crisis*, 1984, p. 165). Given this situation, the figures for unemployment have little credibility. Significantly, when the National Census and Statistics Office (NCSO) used the old criteria of having worked one hour within the past week, the unemployment rate "shot up" to almost 15 percent, arguably a more reliable figure.

Closer to health, nutrition statistics have always been sensitive matter, treated almost like state secrets. The Food and Nutrition Research Institute (FNRI) conducted national surveys on nutrition intake in 1978 and 1982. The results of the 1978 survey were printed in the National Economic and Development Authority (NEDA)'s Statistical Yearbooks for 1983 and 1984, without any changes. However, in the 1984 Statistical Yearbook, they also released results of their 1982 survey, indicating a drop in nutritional intake for protein, iron and ascorbic acid when compared with the 1978 figures.

In the 1985 NEDA Statistical Yearbook, we noticed that the 1978 figures had been changed — several figures were lowered so that now, protein and iron intake seems to have *increased* for 1982. When interviewed, FNRI researchers said the changes in the 1978 figures had been made because of the discovery of "human error" and the use of "new food composition tables" which meant differences in the nutrient value of the different food items. Another government nutritionist, who naturally prefers to remain anonymous, observed wryly, "I guess the nutrient values of things like fruits and vegetables were lower in 1978."

Under-registration and Over-registration

Certainly, no survey is perfect. Given the situation in the Philippines, it is difficult to gather accurate statistics and this is particularly true for health indices. The Ministry of Health itself admits that for population figures, there is underregistration of 16% on a national basis and in certain areas of Mindanao, this under-registration reaches as high as 36.5%. To translate, the official national population figure of about 55 million probably should be closer to 60 million.

There are many reasons for such problems. There are remote barrios where people are born and die without ever being reached by government census-takers. In terms of disease statistics, there are villages that have never seen a health professional, so their diseases never get to be reported, even if an epidemic wipes out half of the village's children (whose births were probably never reported either).

Over-registration in terms of diseases and death is not likely to occur; but figures could be inflated regarding other social indices such as income. In such cases, errors may be due to the interviewer or the people being surveyed. Many factors enter the interview process and sensitive information may not be divulged, or are changed.

The "human errors" could enter during the stage of data collation, inadvertently or advertently, the latter known of course as "doctoring" of statistics. In all fairness, doctoring of statistics is not always easy to do and the miraculous changes reported for malnut-

rition rates, for instance, may also be due to problems in the field. In Kalinga-Apayao, for instance, the rate of third-degree malnutrition (the most severe form) reportedly dropped from 10.8% to 5.8% between 1976 and 1977, supposedly following intervention in the form of feeding programs. (Cf. Antonio Lim, *Productivity and Consumer Welfare: The Relationship Between Food Production and Nutrition*, mimeo, n.d., p. 14) Giving enough benefit of a doubt, one could assume that the peace and order situation prevented a more accurate follow up of the children. A government physician, again preferring to remain anonymous, puts it more morbidly: "Of course the number of third degree malnourished children dropped: most of them died."

Interpretation

In the past, it took years for government health and nutrition statistics to be released, fueling suspicions about doctoring. And when figures were finally released, they were usually given in confusing tables, accompanied by even more confusing text "explanations". Hand these to journalists or writers without medical background and the problem is further compounded.

Let's use nutrition again as an example. Figures for under-nutrition, for instance, now include only those suffering from second and third degree malnutrition. Since a large percentage of children suffer from first degree ("mild" which one must remember always carries potentials of turning into "moderate" or "severe") under-nutrition, it is easy to deceive the public into believing that the number of under-nourished children has really dropped through the years.

Still on nutrition, journalists are also prone to further misinterpretation of statistics. In January 1984, the FNRI issued a press release boasting that in their 1982 survey, moderate and severe malnutrition "were found in only 9.5 percent of the children, representing a 30 percent improvement compared to 1978." Three months later, a reporter wrote up an article saying that "severe and moderate malnutrition had been reduced from 30 percent in 1978 to 9.5 percent in 1982." Same numbers, but different syntax, giving a completely different picture.

Other examples could be cited, where the search for sensationalism or plain inaccuracy can be disastrous. AIDS diagnostic tests, for instance, only indicate *exposure* to the disease, but when figures for positive cases for such tests are released to the press, journalists pounce on these figures and come up with something like "50,000 Australians Afflicted with AIDS".

Politics and Statistics

At the bottom line, the biggest obstacle researchers face in trying to get good statistics is politics. Politicians cite numbers which fit their interests. Note that in some instances, it may even mean citing "bad" statistics. Under the Marcos regime, the health ministry tried for years to minimize publicity on the incidence of tuberculosis in the country, or cited alleged advances in its control as shown by the tiny annual decreases in morbidity and mortality as reported in their Philippine Health Statistics. Later on, MOH put out television ads with an ominous announcement that "17 million Filipinos have tuberculosis", almost one third of the total population. The reason: the ministry is working to get international grants and loans for a tuberculosis control program which is actually targetting only about 350,000 cases, the sputum positive ones. But in that case, never mind the public image for now — the money is more important.

Politics and statistics are wonderful bedfellows when it comes to getting grants and loans. Either boast of non-existent achievements, or paint a grim picture of the present. What is lost in all the manipulation of these statistics is that we are dealing with a "numbers game", that statistics are meant to be parameters or measurements of problems of people. One noted scientist once observed, "Statistics are people with the tears washed away." Unless we learn to look at the people behind the statistics and the graphs, then those numbers will continue to be mystified and academic, a waste of paper and ink. As we look at the statistics compiled here, it would be helpful if we remember still another aphorism: "A thousand deaths a statistic, a single death a tragedy." For those involved in communities, this is a fact one confronts on a daily basis and there are times when one becomes numbed to the sterile ciphers which obscure the pain accompanying the needless infant deaths, the starving toddlers, the languishing tuberculosis patients.

In presenting the following sets of statistics, we hope that community-based groups and other research organizations can start to do their own surveys, using methods of participatory research so that communities cease to be passive objects of study. Statistics are powerful tools, particularly when they help in the work towards social transformation.

Table 1. Leading Causes of Mortality (Rate/100,000)

	1979-1983
1. Pneumonias	93.8
2. Diseases of the heart	65.6
3. Tuberculosis, all forms	57.2
4. Diseases of the vascular system	44.9
5. Malignant neoplasms	33.1
6. Gastro-enteritis and colitis	30.1
7. Accidents	17.0
8. Avitaminosis and nutritional deficiencies	14.5
9. Measles	13.7
10. Chronic obstructive pulmonary diseases	12.2

Source: Bureau of Medical Services, Ministry of Health.

Table 2. Leading Causes of Infant Mortality (Rate/100 Live Births)

	1979-1983
1. Pneumonias	11.1
2. Respiratory conditions of the newborn and fetus	5.8
3. Gastro-enteritis and colitis	4.2
4. Congenital anomalies	2.1
5. Avitaminosis and other nutritional deficiencies	2.0
6. Birth injury and difficult labor	1.4
7. Measles	1.2
8. Chronic obstructive pulmonary diseases	1.0
9. Acute respiratory infections	0.9
10. Meningitis	0.6
11. Tetanus	0.1

Source: Bureau of Medical Services, Ministry of Health.

Table 3. Leading Causes of Morbidity (Rates/100,000)

	1979-1983* (average)
1. Chronic Obstructive Pulmonary Diseases (Bronchitis, emphysema, asthma)	527.2
2. Gastroenteritis and colitis	465.3
3. Influenza	442.1
4. Pneumonias	242.2
5. Tuberculosis, all forms	222.5
6. Malaria	85.0
7. Dysentery, all forms	65.9
8. Measles	65.6
9. Malignant neoplasms	51.2
10. Whooping cough	38.3
11. Accidents	n.a.
12. Infectious hepatitis	19.1

Source: Bureau of Medical Services, Ministry of Health.

Table 4: Health Facilities in the Philippines, 1984

1. Hospitals (Government)	403
(Private)	1,199
2. Rural Health Units	1,991
3. Barangay Health Stations	7,991
4. Sanitaria	8
5. Chest Clinics	17
6. Skin Clinics	22
7. Family Planning Clinics	1,842
8. Social Hygiene Clinics	30
9. Dental Clinics	652
10. Mental Hygiene Clinics	25
11. Malaria Units	33
12. Schistosomiasis Units	23
13. Filariasis Control Units	3
14. Nutriward Units	188

Source: Ministry of Health Bureau of Medical Services.

Table 5: Number of Rural Health Units and Barangay Health Stations

	Rural Health Units	Barangay Health Stations
1960-1961	345	----
1965-1966	1383	----
1969	1459	----
1976	1506	3023
1980	1991	7353
1985	1991	7991

Sources: Data before 1980 as cited in Nestor N. Pilar *et al.*, 1976. Social Development Policies and Programs in the Philippines: Focus on the Delivery of Health Services. University of the Philippines, College of Public Administration.

Data for 1980 and 1985 from the Bureau of Medical Services, Ministry of Health.

Table 6: Government and Private Hospitals, Number and Bed Capacity, Philippines: FY 1969-70 to CY 1984

Year	Number of hospitals			• Bed capacity		
	Government	Private	Total	Government	Private	Total
1969-70	220	430	650	19,725	20,564	40,289
1970-71	209	431	640	20,400	20,573	41,153
1971-72	244	449	693	21,700	21,424	43,124
1972-73	254	514	768	22,325	23,661	45,986
1973-74	275	570	845	39,451	25,594	65,045
1975	363	606	969	41,692	28,082	69,774
1976	366	670	1,036	44,525	31,075	75,600
1977	371	779	1,150	45,161	34,460	79,621
1978	328	837	1,165	29,975	36,179	66,154
1979	335	1,075	1,410	31,050	39,841	70,891
1980	345	1,083	1,428	31,850	38,279	70,129
1981	353	1,097	1,450	32,120	32,875	64,995
1982	360	1,127	1,487	31,830	38,573	70,403
1983	374	1,179	1,553	35,880	38,955	74,835
1984	403	1,199	1,602	31,403	39,205	70,608

Source: Bureau of Medical Services, Ministry of Health.

Table 7: Hospital Beds under the Ministry of Health 1983

	No. of Beds	% of Total Beds	% of Total National Population
National Capital Region	9225	30.6	12.5
Region 1 (Ilocos)	2525	8.3	7.2
Region 2 (Cagayan Valley)	1825	6.1	4.6
Region 3 (Central Luzon)	1825	6.1	10.0
Region 4 (Southern Tagalog)	2775	9.2	12.9
Region 5 (Bicol)	1525	5.1	7.2
Region 6 (Western Visayas)	1950	6.5	9.3
Region 7 (Central Visayas)	1625	5.4	7.7
Region 8 (Eastern Visayas)	1875	6.2	5.7
Region 9 (Western Mindanao)	1250	4.1	5.3
Region 10 (Northern Mindanao)	1630	5.4	5.8
Region 11 (Southern Mindanao)	1250	4.1	7.0
Region 12 (Central Mindanao)	875	2.9	4.8
	30,155	100.0	100.0

Source: Ministry of Health for hospital beds.

Population figures from NEDA, Unified Philippine Development Program, p. 51.

It should be emphasized that the computations made on regional hospital bed: population ratios are based on population figures which have been questioned. The Ministry of Health's own 1981 National Health Survey suggests that under-registration is as high as 36.5% in Western Mindanao, 33.1% in Eastern Visayas and 26.8% in Central Mindanao; therefore, the discrepancies in terms of hospital beds: population ratios may actually be much higher than the already dismal figures.

Table 8. Boosted Medicare Allowances for Dependents

Allowances have been boosted for dependents of members of Medicare, the government's health insurance plan. In May, 1984, a presidential order was issued increasing Medicare allowances for members, but not for dependents. The increases will now cover both members and their dependents. The new rates are as follows:

1. Room and Board	
Primary Care Hospitals	₱16/day
Secondary Care Hospitals	₱22/day
Tertiary Care Hospitals	₱30/day
2. Drugs/Laboratory Examination	
Ordinary Cases	₱175 maximum
Cases Requiring Intensive Care	₱350 maximum
3. Surgeon's Fees	
Minor Surgery	₱65 maximum
Medium Surgery	₱325 maximum
Major Surgery	₱650 maximum
4. Operating Room Fee	
Minor Surgery	₱20
Medium Surgery	₱50
Major Surgery	₱100
5. Anesthesiologist's Fee	30% of Surgeon's Fee
6. Medical/Dental Practitioner's Fee	
Ordinary Cases	₱15/day maximum
	₱200/SPC
Cases Requiring Intensive Care	₱300/SPC maximum

The new allowances are still considered inadequate given the present costs of drugs and other hospital fees. Earlier, allowances for sterilization were doubled, with the allowance now ₱200 for vasectomies and ₱300 for tubal ligations.

The new allowances go into effect on January 20 but note that additional Medicare contributions will be collected starting in 1987.

Source: BT, January 23, 1986.

**Table 9. Salary and Allowances of Allied Medical Positions
in the Ministry of Health, Philippines**

	No. of Positions	M o n t h l y				Total Monthly	Total Annual
		Salary	Cola	Others	Total		
Med. Positions							
Physicians	8,970	2,553	300	235	3,088	27,699,360	332,392,320
Allied Medical Positions							
Nurse	13,655	774	350	235	1,359	18,557,145	222,685,740
Dentist	1,915	1,043	350	231	1,624	3,109,960	37,319,520
Pharmacist	616	855	350	235	1,440	887,040	10,644,480
Med. Tech.	832	855	350	235	1,440	1,198,080	14,376,960
Chemist	235	855	350	235	1,440	338,400	4,060,800
Health Educator	133	855	350	25	1,230	163,590	1,963,080
Nutritionist	300	898	350	25	1,273	381,900	4,582,800
Dietitian	520	774	350	235	1,359	706,680	8,480,160
Occupational Therapist	53	774	350	235	1,359	72,027	864,324
Physical Therapist	30	774	350	235	1,359	40,770	489,240
Hosp. Licensing Officer	12	1,894	300	25	2,219	26,628	319,536
Health Physicist	11	1,894	300	25	2,219	24,409	292,908
Clinical Psychologist	8	1,272	350	235	1,857	14,856	178,272
Zoologist	6	1,211	350	25	1,586	9,516	114,192
Entomologist	22	1,096	350	25	1,471	32,362	388,344
Bacteriologist	69	898	350	235	1,483	102,327	1,227,924
Malariologist	53	813	350	25	1,188	62,964	755,568
Medical Radiation Technologist	12	774	350	235	1,359	16,308	195,696
Midwives	8,694	603	350	25	978	8,502,732	102,032,784
Sanitary Inspector	2,260	546	350	25	921	2,081,460	24,977,520
Sub-Total	29,436					36,329,154	435,949,848
Grand Total	38,406					64,028,514	768,342,168

Note: Total amount based on lowest level of position class. Figures as of 1985, excluding the 25% salary increase granted through Executive Order 1061.

Source: Office of Compensation and Wage Classification, Ministry of Budget.

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Biographical Notes

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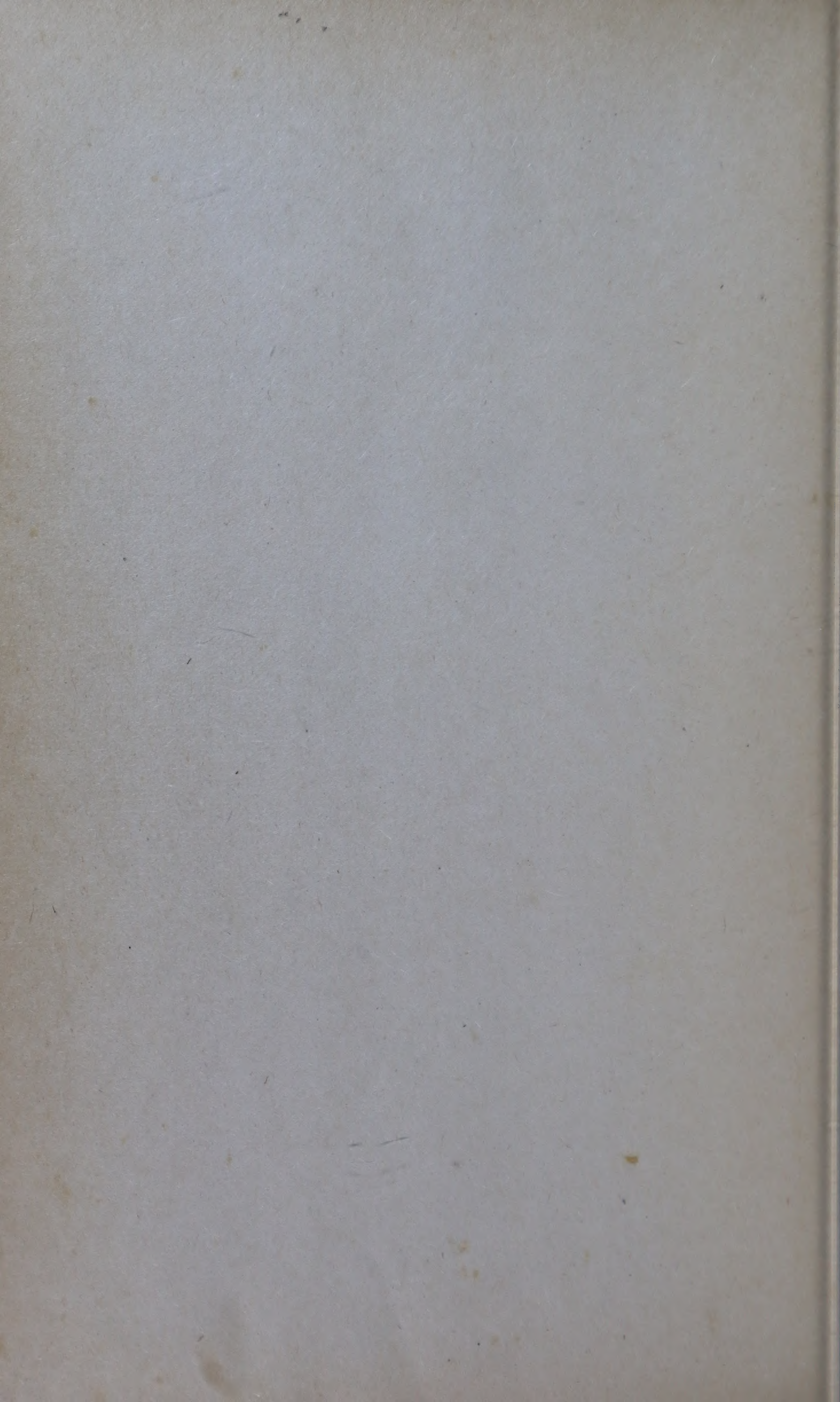
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Caring Enough to Cure

Diagnosing the Disease-Poverty Syndrome

Accurate medical diagnosis is the key to successful therapy. This book offers a diagnosis of the Philippine health delivery system, a difficult but important task considering its critical state.

In lay person's terms, this book seeks to explain the facts behind the cold figures of morbidity, mortality and malnutrition. It reexamines myths surrounding health and medicine, challenging medical elitism and the compulsion to equate effective health care with miracle drug cures, high-rise hospitals and high-tech medical gadgets . . . all of which do exist in the Philippines even as the health problems remain basically unchanged over the last decades.

This book was produced on the premise that health and illness are social phenomena, determined not just by germs, but also by economics and political will. It probes for answers to the nagging question of why Filipinos view simple, preventable and curable illnesses as major catastrophes. It also asks other questions — "Why are drug prices high?", "Why is there less access to doctors and nurses even as medical and nursing schools proliferate?" — which can no longer be evaded, even by the most jaded physician, politician or pharmaceutical executive.

The challenge is to start caring enough, confronting realities and daring, as others have, to transform that caring into concrete action. What we hope to see are not more doctors, disease palaces or drugs in a health delivery system, but the emergence of a humane health care system as every person assumes individual and collective responsibility in combatting illness and maintaining health.

**Council for Primary Health Care
Manila, Philippines**

